HEALTH CARE FINANCING ADMINISTRATION
SPECIAL TERMS AND CONDITIONS

JULY 15, 1997
AMENDED JUNE 21, 2001

NUMBER: 11-W-00114/2

TITLE: The Partnership Plan

AWARDEE: New York State Department of Health

PREFACE

The following are terms and conditions for the award of the New York State Partnership Plan 1115 demonstration waiver request. The terms and conditions have been broken down into 6 broad subject areas and a series of attachments. The broad subject areas include the following: Operational Conditions for Approval, Legislation, Program Components, Medicaid Management Information Systems (MMIS), General Program Requirements, and General Reporting Requirements. The attachments include specific requirements relating to: General Financial Requirements (Attachment A), Budget Neutrality (Attachment B), the required Operational Protocol (Attachment C), Access Standards (Attachment D), the Phase-in Approach to Enrollment (Attachment E), Enrollment of HIV-positive Individuals (Attachment F), Enrollment of the Seriously Mentally Ill (Attachment G), the Milestone Approach to the Development of Special Needs Plans (SNPs) (Attachment H), Persons and Services Subject to the Budget Neutrality Cap (Attachment I), Terms and Conditions Associated with the Community Health Care Conversion Demonstration Project (Attachment J), and Encounter Data Set Elements (Attachment K), Guidelines for Quarterly Reporting on New York's Partnership Plan Section 1115 Demonstration (Attachment L), and Family Health Plus Benefits (Attachment M). The New York Department of Health agrees to abide by these specifications and attachments. Generally, the term "Partnership Plan" refers to The Partnership Plan and Family Health Plus (FHPlus). However, specific provisions related to the mandatory enrollment process, auto assignment, the availability of fee-for-service, and Medicaid managed care service definitions do not apply to FHPlus. The FHPlus program is a Medicaid expansion under which enrollees receive a comprehensive but limited package of health care services (as defined in Attachment M) through managed care organizations. There is no fee-for-service component or wrap around coverage for FHPlus. Enrollees in FHPlus are adults ages 19 through 64 who do not have equivalent health care coverage, and are not eligible for traditional Medicaid solely due to income or resource requirements. To be enrolled in FHPlus, an applicant must select an MCO.

All special terms and conditions prefaced with an asterisk (*) contain requirements that must be approved by the Health Care Financing Administration (HCFA) prior to marketing, enrollment, or implementation of any aspect of this demonstration not previously implemented under the State's 1915(b) waivers or voluntary programs (which will be fully subsumed within the approved 1115 program). In addition, such activities shall not be implemented prior to HCFA approval of each stage of the phase-in plan, as delineated in Attachment E. No Federal Financial Participation (FFP) will be provided for any marketing, enrollment or implementation until HCFA has approved these requirements. FFP will be available for demonstration development and implementation, and for compliance with terms and conditions, the readiness review, etc. Unless otherwise specified, where the State is required to obtain HCFA approval of a submission, HCFA will respond to the submission in writing within 45 days of receipt from the State.

The local districts of social services= (LDSS) contracts with managed care organizations (MCOs) must incorporate all requirements included in these terms and conditions that are different from those specified in the Request for Proposals (RFPs) for the procurement of MCOs dated November 15, 1995.

Unless otherwise specified in these terms and conditions, all Partnership Plan enrollees, whether enrolled in mainstream MCOs or SNPs, are afforded all protections in accordance with the provisions of Chapters 649 and 705 of the laws of 1996. Contracts with MCOs must include language that permits enforcement of the provisions in these terms and conditions and all applicable provisions as set forth in the New York laws (except those that are superseded by these terms and conditions). As used herein, the term “managed care organization” (MCO) shall also include any indemnity plan approved by the state and by HCFA for participation in FHPlus. The requirements for these plans will be specified in both the contracts and the operational protocol document.

The State agrees that it will comply with all applicable Federal statutes relating to nondiscrimination. These include, but are not limited to: the Americans with Disabilities Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. As part of the review of the protocol that the State is required to submit, the Department of Health and Human Services will examine the State=s proposed operational procedures to ensure their consistency with the requirements set forth in the above Federal statutes.

Letters, documents, reports, or other materials that are to be submitted for review or approval shall be sent to The Partnership Plan Project Officer and HCFA=s New York Regional Office.

Table of Contents

Table of Contents

Approved NY Partnership Plan Terms and Conditions
July 15, 1997
Amended June 21, 2001

I. OPERATIONAL CONDITIONS FOR APPROVAL

A.* Waiver of Section 1902(a)(23) and regulations at 42 CFR, Subpart B, Section 431.51 (freedom of choice), and authorization of Federal matching for expenditures that do not comply with Section 1903(m)(2)(A)(vi) and regulations at 42 CFR, Section 434.27(b)(1) and (2) (lock-in provisions) will not be effective until such time that the Health Care Financing Administration (HCFA) approves in writing that the State is in compliance with the terms and conditions specified within the Eligibility, Benefits, Beneficiary Marketing, Education and Enrollment/Disenrollment, Delivery Network, Quality Assurance, MMIS Systems and General Program Requirements section of this document.

Specifically, the above-referenced waivers and matching authority will only be granted in boroughs and counties where HCFA has certified the participation of individual MCOs, and the general operational readiness of specific boroughs and counties in accordance with a phase-in plan, as delineated in Attachment E. Federal matching payments will be provided for all Home Relief recipients, effective the first day of mandatory enrollment under the demonstration, whether they are enrolled in managed care organizations or not. HCFA=s certification process will include a detailed review of both State and MCO readiness, as delineated in these terms and conditions and attachments. Approval of MCO participation will be granted based on the readiness and capacity of the MCO to enroll beneficiaries and documentation that there is sufficient provider capacity to serve the area. Before beneficiaries can be enrolled with the MCO, the MCO contract must be approved by HCFA.

B.* After approval of the demonstration, the State shall prepare one protocol document that thoroughly represents the demonstration policies and operating provisions which have been agreed to by the State and HCFA. Within 30 days of receipt of the protocol, HCFA will identify, in writing, all significant issues that are to be addressed by the State, and will work with the State toward approval of the final protocol document within 60 days. This 60-day period does not include the period in which the State is responding to HCFA=s written comments and questions on the protocol. The policy and operational areas to be addressed in the protocol are outlined in Attachment C and in specific terms and conditions throughout this document.

In order to facilitate the beginning of Phase I mandatory enrollment under this demonstration (see Attachment E of this document for other requirements of the phase-in process), HCFA will conduct a review of 1915(b) waiver program implementation in those counties scheduled for inclusion in Phase 1. In light of the fact that the Phase 1

counties for the 1915(b) and 1115 waiver programs are the same, during the first month of implementation of the 1915(b) program, HCFA will undertake a 30-day review designed to identify issues in key areas, including but not limited to, the enrollment process, marketing, systems readiness, and adequacy of provider networks. If no significant issues are found during this review period, HCFA will authorize the implementation of Phase 1 of the Partnership Plan 1115 demonstration within 60 days of the implementation of the 1915(b) program, or upon approval of the 1115 Operational Protocol and completion of the Phase 1 readiness review, whichever comes first.

C. Since FHPlus will not be phased-in by county or zip code, the above- referenced waivers and matching authority applicable to FHPLus will be granted statewide upon implementation of the FHPlus program and will not be subject to the Phase-in plan as delinated in Attachment E.

D. The State will request modifications to the demonstration by submitting a written request, with a detailed justification, to HCFA for approval. All desired modifications are to be submitted to HCFA at least 90 days prior to the desired date of implementation of the change.

E.* Within 60 days after award, the State will submit a demonstration work plan for approval by the HCFA project officer. The work plan will specify time frames for completion of major tasks and related subtasks for The Partnership Plan, including all requirements specified within this document.

II. LEGISLATION

A. All requirements of the Medicaid program expressed in law not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part, shall apply to The Partnership Plan. To the extent the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, HCFA shall incorporate such effects into a modified budget limit for The Partnership Plan 1115 program. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. HCFA will have two years after the waiver award date to notify the State that it intends to take action. The growth rates for the budget neutrality baseline, as described in Attachment B, are not subject to this special term and condition. If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by The Partnership Plan section 1115 demonstration, the effect of enforcement on the State's budget limit shall be proportional to the size of The Partnership Plan demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

B. The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after July 15, 1997. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of the waiver, HCFA shall incorporate such changes into a modified budget limit for The Partnership Plan section 1115 demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program components that are or are not affected by The Partnership Plan section 1115 demonstration (e.g., laws affecting sources of Medicaid funding), the State shall submit its methodology to HCFA for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in New York, HCFA will approve the methodology. Should HCFA and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction or increase in Federal payments shall be made according to the method applied in non-waiver States.

C. The State may submit to HCFA a request for an amendment to The Partnership Plan program to request exemption from changes in law occurring after July 15, 1997. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under a modified Partnership Plan 1115 demonstration program do not exceed projected expenditures in the absence of the Partnership Plan 1115 demonstration (assuming full compliance with the change in law).

III. PROGRAM COMPONENTS

A. Eligibility

1. Individuals eligible for The Partnership Plan will be those described in the operational protocol approved by HCFA. Any future changes in eligibility under The Partnership Plan must be submitted to HCFA as an amendment for approval.

2. Medicaid Eligibility Quality Control - Within 60 days of the date of award, the State of New York must advise HCFA if it wants to conduct traditional Medicaid eligibility quality control (MEQC) activities or develop new methodologies. If the State decides to develop new methodologies, a detailed description of those activities must accompany the State=s correspondence to HCFA. New methodologies are subject to review and approval by HCFA.

   If the State does not want to be held liable for the withholding of Federal financial participation (FFP) for an error rate exceeding the 3 percent tolerance, either for non-demonstration Medicaid beneficiaries or demonstration eligibles, it may request, under section 1115 waiver authority, that HCFA allow the State to implement a new approach to MEQC, and receive FFP not otherwise available.

   If the State does not submit an alternative method within this time frame, the State will maintain its current MEQC program for its demonstration and non-demonstration populations.

B. Benefits

1. Coordination of Services

   a. Linkage Agreements/Coordination of Care - As part of the required protocol, the State will develop, and submit for approval, a detailed plan that describes how MCOs are expected to develop linkage agreements and coordinate care for their Partnership Plan enrollees in each borough and county with: school-based health clinics, the court system (i.e., for court-ordered evaluations and treatment), family planning clinics, SNPs, programs funded through the Ryan White CARE Act, providers of health care for the homeless, shelters and other providers of services for victims of domestic violence, Prenatal Care Assistance Program providers, community health centers, migrant health centers and other pertinent entities that provide services out of network. Coordination may involve MCO contracts or linkage agreements or other mechanisms to assure care for these individuals.

   b. Coordination and Payment of Out-of-Network Services - MCOs will be responsible for reimbursement of care provided outside the network if there is no network provider with appropriate training and expertise to meet Partnership Plan enrollees= needs. In addition, if there is no subcontract for particular types of medically necessary specialist services for which the MCO is liable, the MCO

will be responsible for arranging for the provision of such services and reimbursing the specialty providers on a fee-for-service basis.

c. Coordination of Care for Partnership Plan Enrollees in Need of Mental Health and Substance Abuse Treatment Services - The State shall ensure that mental health and substance abuse conditions are systematically identified and addressed by the enrollee's primary care provider (PCP). As part of the protocol, the State shall provide a description detailing how MCOs will meet the requirements for actively identifying enrollees in need of mental health and substance abuse treatment services and ensure that they receive appropriate care. The protocol shall include a description of how MCOs are expected to:

- target high-risk populations;
- utilize screening tools; and
- coordinate PCP services with mental health and substance abuse treatment services.

The protocol must describe how the MCOs will ensure that the PCPs in the network have the necessary skills and expertise to identify mental health and substance abuse problems, and make appropriate referrals. The protocol must also include a description of how enrollees will be informed of their right to self-refer for a mental health or substance abuse assessment from a MCO network provider. In addition, the protocol must include a description of the procedures for monitoring MCOs to ensure that these responsibilities are carried out.

Grievances and complaints regarding access to mental health or substance abuse services shall be reported quarterly, as part of section III, Program Components, subsection (E)(3)(b).

2. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services - The State shall ensure that EPSDT standards and responsibilities are clearly communicated to participating providers and that those providers arrange for, or provide, the full range of EPSDT services.

3. Drug Benefits - All enrolled individuals shall have access to all medically necessary and clinically appropriate Food and Drug Administration (FDA)-approved drugs (either brand name or generic) and combinations of drugs for their conditions/diseases. Individuals that experience problems accessing treatment without which could significantly increase the risk to the enrollee=s health may avail themselves of the expedited complaint process which is to be described as part of the complaint and appeal section of New York=s operational protocol. See Section III.E.3.b. of these special terms and conditions for the requirements on expedited complaint procedures. The State shall have in place a mechanism for monitoring the adequacy of a MCO=s formulary and timely access to medically necessary services. The State may require a MCO to provide pharmaceutical services to an enrollee, as appropriate, until a resolution is made concerning an enrollee=s alleged problem accessing treatment. The State is ultimately

responsible for ensuring that Medicaid beneficiaries receive medically necessary services while pursuing complaints through the MCO or State complaint and appeals process.

4. Institutions for Mental Diseases (IMDs) - Payments for Partnership Plan (managed care) enrollees aged 21 through 64 in IMDs shall be limited to inpatient stays of up to 30 consecutive days per episode, while enrolled in the MCO,or for up to 60 inpatient days for each eligible individual enrolled in a MCO per year.

5. Any changes in the benefit package provided to any recipient covered under The Partnership Plan from that delineated as part of this Demonstration Waiver Program, as described in the approved operational protocol, will require an amendment to the operational protocol document and must be approved by HCFA.

6.* Contracts with MCOs will have language that permits enforcement of the above provisions, and all applicable provisions as set forth in Chapters 649 and 705 of the laws of 1996.

C. Beneficiary Marketing, Education & Enrollment/ Disenrollment

For FHPlus, the following conditions will apply with the exception of requirements related to exempt and excluded populations, disenrollmnets into fee-for-service, and auto assignment.

1. Marketing

a.* The State will provide guidelines to and work with LDSSs to approve all Partnership Plan direct marketing material. The State shall, however, retain full responsibility for ensuring that plans are in compliance with the marketing guidelines. (Direct marketing material for The Partnership Plan includes marketing materials in several media, including brochures and leaflets, newspaper, magazine, radio, television, billboard, and yellow page advertisements, and presentation materials used by marketing representatives.) Written marketing material should not exceed a fourth grade reading level. In reviewing direct marketing material, the State may want to consider the Medicaid Managed Care Marketing Guidelines, issued on August 25, 1994. HCFA reserves the right to review marketing plans and direct marketing materials prior to dissemination, if deemed necessary.

b. MCOs shall be prohibited from telephone cold calling and door-to-door solicitation at the homes of medical assistance recipients. MCO providers are only permitted to assist participants in the completion of enrollment forms at approved health care provider sites and other approved locations, consistent with State law. In no case may an emergency room be deemed an approved location. Details on the enrollment sites will be provided in the operational protocol. In addition, there shall be no compensation to MCO marketing representatives, including bonuses or commissions, based upon the numbers of individuals they enroll. The full range of State policies with regard to marketing practices must be delineated in the operational protocol (see Attachment C). Documented

marketing abuses by a MCO shall be listed as a reason for contract termination in all MCO contracts. However, beneficiaries who are enrolled as a result of documented deceptive marketing practices may change plans upon request. The State agrees to audit marketing and enrollment practices, including conducting beneficiary surveys, and monitoring the standardized enrollment forms to ensure that they are not duplicated and used outside the approved enrollment guidelines.

c.* The State must require participating MCOs to make available written marketing and other informational materials in languages other than English whenever at least 5 percent of potential Partnership Plan enrollees in a MCO's service area speak a language other than English as a first language. In addition, verbal interpretation services must be made available to Partnership Plan enrollees who speak a language other than English as a primary language. The State must also require participating MCOs to have mechanisms in place to communicate effectively with enrollees who are vision or hearing impaired, e.g., the services of an interpreter, including sign language assistance for enrollees who require such assistance, telecommunication devices for the deaf (TDD), etc.

d.* Contracts with MCOs will have language that permits enforcement of the above provisions, and all applicable provisions as set forth in Chapters 649 and 705 of the laws of 1996.

2. Beneficiary Education/Enrollment/Disenrollment

a. All beneficiary education and enrollment activities will be done by the New York State Department of Health, the Office of Mental Retardation and Developmental Disabilities, and the LDSS or its contractor. The State shall, however, retain full responsibility for all education and enrollment activities undertaken by the LDSSs or their designated agents. All beneficiary and enrollment activities for the mental health SNPs will be conducted by the New York State Office of Mental Health or its designated agent. The State shall submit any contract for an education/enrollment vendor to HCFA for prior review.

b.* Prior to beginning mandatory managed care enrollment in any phase of The Partnership Plan, the State shall ensure that complete information explaining all managed care options that beneficiaries may choose from is readily available and disseminated to all individuals targeted for enrollment. The State, or contracted education/enrollment vendor, shall send each eligible beneficiary information about The Partnership Plan program. Within the enrollment packet, an enrollment form that contains a comprehensive listing of MCOs within the beneficiary=s zip code area and an instruction sheet on how to complete the form will be provided, as well as information on how and where beneficiaries may obtain face-to-face enrollment counseling services, and complete information on MCO networks (see III.C.2.c.). In addition, there will be the following: a statement that informs beneficiaries that they

can choose their current PCP if that provider participates in The Partnership Plan and they must choose a MCO that includes that PCP in its network if they wish to continue to utilize his/her services; information regarding the individual's disenrollment rights; a statement that informs beneficiaries that they must choose a MCO within 60 days or the State will choose for them and of their right to change MCOs within 30 days of the effective date of enrollment with the MCO of their choice or within 60 days if they are auto assigned by the State; information regarding access to transportation services to and from medical care; a statement that informs beneficiaries that there is additional information available and the location where the information can be obtained; and information concerning the availability of assistance through beneficiary hot lines.

Further, there should be language that informs beneficiaries how long they are locked into their MCO, unless there is good cause to change MCOs, and that all services must be obtained or coordinated through their MCO except services designated for self-referral (e.g., family planning).

c.* The following information on The Partnership Plan shall be made available at all LDSS enrollment offices in designated borough(s) and counties that have been certified by HCFA to begin enrollment (as described in Attachment E):

- A comprehensive listing of all MCOs, and their complete provider networks, including PCPs, specialists and sub-specialists, hospitals, pharmacies, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), etc., serving the designated borough(s)/counties that have been certified by HCFA to begin enrollment. At a minimum, the list should contain: corporate and common practice name, office locations, hours, telephone numbers, address(es), and the ability to accommodate other languages.

d.* The State will ensure that a sufficient number of beneficiary hot lines in different languages are available and publicized to accommodate concerns and questions of beneficiaries prior to enrollment in certified boroughs and counties during the course of the demonstration program. The State will develop and maintain an acceptable standard for hotline access. The State will monitor: a) the number of overflow calls, i.e., calls not answered due to a busy signal; b) the average duration of each call; c) the total number of calls handled per day/week/month; d) the average calls per day; e) the busiest area code; and f) the busiest day by number of calls. In addition, hot lines will be operated in a manner that guarantees access to interpretation services. HCFA reserves the right to request detailed information on hot line activity during the course of the demonstration.

e. Individuals with a chronic medical condition who are being treated by a sub-

specialist physician, who is not part of any MCO network available in the participant=s service area, will not be required to enroll in a MCO and may continue to receive care on a fee-for-service basis. (Individuals with HIV disease (defined as individuals who are HIV-positive and asymptomatic, individuals with symptomatic HIV disease and individuals with symptomatic AIDS), seriously and persistently mentally ill (SPMI) adults, and seriously emotionally disturbed (SED) children will be covered by this exemption and by the stipulations in Attachments E, F, and G.) This exemption applies until such time as the individual's course of treatment is completed, recognizing that in some cases, the course of treatment will continue indefinitely. As part of the required protocol, the State must define the criteria to which this term and condition apply; specify how such individuals will be identified; and the process for exempting these individuals from managed care. The State shall develop an exemption form that will be used by such individuals to request an exemption from mandatory enrollment. The State shall also define the types of sub-specialists to whom this provision will apply. In addition, individuals who have chronic diseases or conditions and cannot obtain specialist care within the network, or who do not have access to PCPs with appropriate expertise, must be allowed to disenroll from the MCO within 30 days of a request for disenrollment accompanied by submission of documentation of their illness. These individuals can enroll in any available MCO in their service area.

The State shall institute and maintain a process whereby individuals with unusually severe chronic care or complex referral needs can: a) apply for an exemption from managed care enrollment under The Partnership Plan; or b) if enrolled in a MCO, apply for disenrollment. If an exemption or disenrollment is granted, such individuals will receive care on a fee-for-service basis. The operational protocol must delineate the process by which individuals may apply for an exemption or disenrollment, and the criteria that will determine whether exemptions or disenrollments will be granted.

f. <u>Selection of MCO</u>

- The following provisions shall apply to eligible Partnership Plan participants' selection of MCOs.

- All eligible Partnership Plan enrollees shall have a minimum of 2 MCOs from which to select.

- All individuals eligible for The Partnership Plan shall have access to a face-to-face enrollment counseling session (either group, or individualized counseling for those who request it) with either an enrollment broker or LDSS staff, prior to their enrollment in the program. The State shall assure that all individuals responsible for providing face-to-face enrollment counseling services are adequately trained. All eligible individuals shall have 60 days after receipt of information about managed care choices, in which to select a MCO. If

eligible individuals fail to select a MCO within 60 days, the State may assign them to a MCO, in accordance with a predetermined default assignment algorithm. If beneficiaries participate in a face-to-face counseling session near the end of the 60-day selection period, they must still select a plan within the 60-day time frame. The operational protocol shall specify when the 60-day period begins.

- Eligible individuals who receive enrollment material in the mail and do not participate in a face-to-face enrollment session shall have 60 days, subsequent to receipt of the information, in which to select a MCO. Eligible individuals who have not selected a MCO within this time period may be assigned to a MCO by the State.

- The State shall incorporate a process for following up with eligible individuals who have participated in a face-to-face enrollment counseling session, and those who have received mail enrollment material, to assist them in making a decision regarding choice of MCO **prior to the end of the 60-day period.** The operational protocol must include a description of this process.

g. During the phase-in part of the demonstration, if the auto-assignment rate in any county or borough that has begun mandatory enrollment falls between **40 and 50 percent**, the State must investigate the reason for this rate by conducting methodologically appropriate surveys and/or focus groups. If the auto assignment rate exceeds **50 percent**, the State must develop and implement a corrective action plan. Immediately following the completion of mandatory enrollment in each phase, this initial threshold will be reduced to **40 percent**.

h. At a minimum, the MCO will send, within 14 days of the effective date of enrollment, the MCO member handbook and identification card to all beneficiaries who select or who are assigned to the MCO. If unforeseen circumstances prevent the MCO from forwarding the approved member handbook and official identification card to new enrollees within the 14-day period, a welcome letter or temporary identification card would be acceptable. However, under no circumstances should a welcome letter or temporary identification card serve as a substitute for an approved member handbook or official identification card.

i. All Partnership Plan enrollees who are in a MCO for the first time may change MCOs for any reason within 30 days of their effective date of enrollment if they have selected the MCO and within 60 days if they have been autoassigned. This requirement is applicable in New York City only after all phases of the city have been implemented. Until such time as all phases have been implemented,

Partnership Plan enrollees in New York City may change MCOs for 90 days after selection of or auto-assignment to a new MCO. With respect to FHPlus, all enrollees will always have 90 days to select an different MCO, if one is available, after being enrolled in a new MCO. A description of how enrollees will be informed of the grace period for changing MCOs, and how the State will ensure that this process is user-friendly and easily accessible to enrollees, must be included in the required operational protocol. The state, in consultation with HCFA, may implement a uniform standard for the time period to change MCOs, provided that such standard not be less than 90 days

j.* MCO Assignment/Enrollment Notices

- The following provisions apply to the process of notifying eligible Partnership Plan participants about the MCOs in which they are enrolled (by either selection or assignment):

- Within 60 days of the date of award, the State must submit to HCFA, for approval, the default assignment algorithm that will be utilized to assign eligible beneficiaries who do not select a MCO in which to enroll. The default assignment algorithm shall include the provisions as outlined in Chapter 649 of the laws of 1996, and shall consider, to the extent possible, existing access and quality factors. Because the FHPlus program does not involve auto-assignment, this requirement does not pertain to FHPlus.

- For eligible individuals assigned to a MCO by the State, at a minimum, 14 days prior to the effective date of enrollment, the State will send a notice of assignment. The notice will give participants the name and telephone number of the MCO to which they have been assigned, and indicate the effective date of enrollment. The notice will also explain the process by which Partnership Plan enrollees may select a different MCO if they so choose, and the time frame for doing so, as well as the process for applying for exemption from MCO enrollment, as delineated in (2)(e) above.

- For eligible individuals who have selected an MCO, the MCO shall send a notice of enrollment at least 14 days prior to the effective date of enrollment. These notices will also explain the process by which Partnership Plan enrollees may select a different MCO if they so choose, and the time frame for doing so, as well as the process for applying for exemption from MCO enrollment, as delineated in (2)(e) above. If clear and persistent problems occur with MCO notifications to newly enrolled beneficiaries--for example, if MCO notifications are repeatedly late or if they repeatedly contain incorrect information--HCFA reserves the right to require the State to send separate notices of enrollment to beneficiaries.

- Eligible individuals who select a MCO which is closed to enrollment will be so notified in writing and given 30 days in which to select a different MCO. If they fail to select a MCO within this time period, the State may assign them, subject to the assignment requirements outlined above. One year following the completion of mandatory enrollment in each phase, the State may request modifications to this time period. However, HCFA will grant approval of such modifications only upon a careful review of the State's experience under these initial provisions.

- The operational protocol will contain a detailed description of the following informational material: a) information provided at the time of a face-to-face enrollment session; b) mailed enrollment material; c) medical assistance cards issued by the State and/or MCOs, and the specific information displayed on such cards; d) the content of assignment, enrollment, and exemption/disenrollment notices, and e) the facilitated enrollment process for FHPlus.

k. Selection of Primary Care Provider (PCP)

a. To the extent possible and appropriate, all Partnership Plan enrollees shall have a choice of PCPs who are accessible and capable of coordinating their health care needs. Enrollees may be auto-assigned to a PCP on the basis of geography if they do not select a provider. Partnership Plan enrollees may change their PCP without cause within 30 days of their selection, and no more than once every 6 months, except for good cause. Good cause reasons for changes in PCP beyond the limits specified in State law must be included in the operational protocol.

b. The State will encourage health plans serving both Medicaid and non-Medicaid populations to make their entire network available to Medicaid enrollees and will, at a minimum, assure sixty percent (60%) of the network will be available in year one of the demonstration and eighty percent (80%) in year two. The degree to which a plan proposes to open its network to Medicaid enrollees will be taken into consideration during the proposed evaluation process, and will also be an important consideration during subsequent procurements. Depending on the degree of mainstreaming achieved in the current process, the State may mandate health plans to open their entire networks during the next qualifying process.

c. Individuals with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialist with expertise in treating the disease or condition. This specialist shall be responsible for and capable of providing and coordinating the enrollee=s primary and specialty care. If the MCO or PCP, in consultation with the MCO medical director and a specialist with expertise in serving the enrollee=s condition or

disease, if available, determines that the enrollee=s care would most appropriately be coordinated by such a specialist, the MCO shall refer the enrollee to such specialist. The specialist shall be permitted to treat the enrollee without a referral from the enrollee=s PCP and may authorize such referrals, procedures, tests and other medical services as the enrollee=s PCP would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan.

d. Only MCO network specialists may function as PCPs under these provisions. The only exception is if a MCO determines that it does not have a health care provider with appropriate training and expertise in its network to meet the particular needs of an enrollee. In such cases, the MCO shall make a referral to an appropriate provider, pursuant to a treatment plan approved by the MCO in consultation with the PCP, the nonparticipating provider and the enrollee or enrollee=s designee, at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within network. The protocol shall include a description of the process by which Partnership Plan enrollees may request a specialist as their PCP, and the criteria that will determine whether such requests will be granted.

D. DELIVERY NETWORK

(Terms 1(a), (b), (c) and (d) below will only apply to RFPs released after the start date of the demonstration. HCFA retains the right to review and approve all contracts prior to their execution.)

1. Network Recruitment

a. Selection Process - A RFP process shall be used to select contracting MCOs. This process will be open to all MCOs that meet participation standards. Before issuing the solicitation for MCOs, the State shall submit the RFP for review by HCFA at least 45 days prior to the release of the document. As part of the solicitation process, the State shall provide potential bidders with sufficient data on cost and utilization, as well as information on how the assumptions regarding cost and caseload were derived in order for the entity to be able to make a knowledgeable and informed decision regarding participation. Potential bidders shall be allotted a sufficient amount of time (at a minimum 45 days) to respond to the RFP.

b.* Contracts & Agreements - The State shall submit all intended model MCO contracts for approval at least 45 days before release of such documents. Any amendment or deviation from these documents must likewise be submitted to HCFA for approval before execution.

c. Subcontracts - HCFA reserves the right to review individual subcontracts. Copies of subcontracts or individual provider agreements with MCOs shall be provided to HCFA upon request.

d.* MCO Payment- A minimum of 30 days prior to the effective date of contracting with MCOs, and at least 30 days before each subsequent contract cycle, the State shall submit for approval all capitation rates, and the fee-for-service upper payment limits from which they are derived. In addition, the methodology for determining the fee-for-service upper payment limits for services must be submitted. The upper payment limit shall not include expenditures associated with IMD services. The State shall include an analysis and certification that its upper payment limits and capitation rates are actuarially sound in accordance with the State's current fee-for-service payment system.

e. Disclosure Requirements - The State will meet the Medicaid disclosure requirements at 42 CFR 455, Subpart B prior to the implementation date of the demonstration. Such requirements include disclosure of ownership and completion of the standard HCFA disclosure form.

2. Capacity

a.* The State will demonstrate to HCFA that sufficient access and capacity under The Partnership Plan are available to potential enrollees prior to the initiation of marketing and mandatory enrollment in each phase of the phase-in plan. The State must provide the methodology it will use to determine whether each MCO approved for contracting in designated boroughs and counties has an adequate provider network in relation to the geographic location of Medicaid beneficiaries (e.g., utilizing a computer mapping program to show average distance between eligibles and primary care/specialty physicians and other providers).

b.* The State will provide a listing of all participating providers (including individual providers in MCOs, by specialty) for each designated borough and county included in a given phase of the predetermined phase-in plan, as outlined in Attachment E. If the provider has multiple MCO affiliations and/or locations under the demonstration, this will include the names of all Partnership Plan MCOs and/or locations with which the provider is affiliated. The State shall also record the reported Medicaid capacity that the MCO's provider network can accommodate. The operational protocol shall include a detailed description of the State=s methodology for determining unduplicated PCP-to-beneficiary ratios. The methodology for this analysis should, at a minimum, take into consideration the incidence of providers affiliated with multiple MCOs. In its review of capacity, HCFA will consider whether the participating MCOs have made appropriate provisions for essential community providers, e.g., FQHCs, public hospitals and hospitals eligible for high need adjustment under the New York State Health Care Reform Act of 1996.

On an ongoing basis throughout the demonstration, the State will promptly report significant changes in any MCO provider network which may affect beneficiary quality of care or access to care (e.g., loss of MCO provider groups or subcontractors with significant Medicaid caseloads, mergers of MCOs, etc.). In

addition, the State shall provide HCFA with an updated list of all MCOs and their provider panels annually, as a part of the annual demonstration continuation application and within 30 days of contract renewals with MCOs.

3. Access

a.* Access Standards - The State must demonstrate, prior to the initiation of enrollment in any phase of the approved phase-in plan, and on an ongoing basis thereafter, that beneficiaries have sufficient access to institutional facilities, service sites, and allied professional services. The methodology for conducting this analysis shall be submitted as part of the operational protocol and should, at a minimum, take into consideration the incidence of providers affiliated with multiple MCOs and the geographic distribution of beneficiaries in relationship to providers. Further, the State shall document that emergency services are available to beneficiaries on a 24-hour-a-day, 7-day-a-week basis. Specific time and distance standards are delineated in Attachment D.

Emergency Services - MCOs under contract with the State to serve Partnership Plan enrollees shall assume financial responsibility and provide reasonable reimbursement for emergency services. Coverage of emergency services extends to coverage of services required in order to determine whether an emergency exists. Participating MCOs are obligated to provide reasonable reimbursement (i.e., a triage fee) for emergency services, as defined at 42 CFR 434.30(b), and any other services needed to ascertain whether an emergency situation exists. This obligation is based on the clinical circumstances that existed at the time of the beneficiary=s presentation to the emergency room. The State has the discretion to determine how to enforce this requirement in its contracts with the MCOs.

c.* MCOs shall have established procedures by which enrollees who require ongoing care from a specialist may receive a standing referral to such specialist. If the MCO, or the PCP, in consultation with the MCO medical director and specialist with expertise in serving the enrollee=s condition or disease, if available, determines that a standing referral is appropriate, the MCO shall make such a referral to a specialist. This referral shall be pursuant to a treatment plan approved by the MCO in consultation with the PCP, the specialist and the enrollee or the enrollee=s designee. Such treatment plan may limit the number of visits or the period during which such visits are authorized and may require the specialist to provide the PCP with regular updates on the specialty care provided, as well as all necessary medical information.

Only MCO network specialists may provide standing referral services under these provisions. The only exception is if a MCO determines that it does not have a health care provider with appropriate training and expertise in its network to meet the particular health care needs of an enrollee. In such cases, the MCO shall make a referral to an appropriate provider, pursuant to a treatment plan approved by the MCO in consultation with the PCP, the nonparticipating provider and the enrollee or enrollee=s designee, at no additional cost to the enrollee beyond what

the enrollee would otherwise pay for services received within network. Partnership Plan enrollees who require ongoing specialty care shall be informed that they have access to standing referrals to a specialist. The protocol shall include a description of the process for requesting a standing referral, and the criteria that will determine whether a standing referral will be granted.

d.* The provisions pertaining to access to specialty care for persons requiring specialized care over a prolonged period of time, as set forth in Chapter 705 of the laws of 1996 shall apply to Partnership Plan enrollees.

e. The State must monitor MCOs to ensure that they are conforming with the standards outlined in the Americans with Disabilities Act (ADA) for purposes of communicating with, and providing accessible services to hearing and vision impaired, and physically disabled enrollees.

f.* Contracts with MCOs will have language that permits enforcement of the above provisions, and all applicable provisions as set forth in Chapters 649 and 705 of the laws of 1996.

4. FQHCs

a.* The State shall, as a general rule, require MCOs to contract with FQHCs in their service area. However, if the State can demonstrate to HCFA that the MCOs have adequate capacity and will provide an appropriate range of services for vulnerable populations without contracting with an FQHC in its service area, the MCO may be relieved of this requirement. If FQHCs sponsor their own MCO, other MCOs in the same service area will not be required to contract with FQHCs.

b.* For any MCO that requests an exemption from the requirement that it contract with FQHCs, the State shall submit to HCFA a report with the following information at least 60 days prior to submission of the final managed care contract for HCFA approval:

1) A list of the FQHCs in the MCO service area, and a description of the demonstration populations served and the services provided by the FQHCs prior to the demonstration.

2) An analysis that the MCO has sufficient provider capacity to serve the demonstration populations currently receiving services at the FQHC. The analysis should include, but not be limited to, a listing of providers affiliated with the MCO/Outpatient Network, capacity of each provider to take on additional Medicaid patients, geographic location of providers and description of accessibility for Medicaid patients to these providers. The MCO/Outpatient Network must inform the State if any of this information or data changes over the course of the demonstration.

3) An analysis that the MCO will provide a comparable level of Medicaid services to that provided by the FQHC (as covered in the approved State Medicaid plan), including such enabling services as outreach, social support services, and culturally sensitive services, e.g., translators and training for medical and administrative staff, etc. The analysis should describe the proximity of providers and range of services available to FQHC patients, in a given service area.

c. The MCO will pay the FQHC(s) on either a capitated (risk) basis (with appropriate adjustments for risk factors) or on a cost-related basis. A description of the payment methodology shall be provided by the State. If during the demonstration, the MCO changes its payment methodology to a FQHC, the changes must be submitted by the State to HCFA for review and approval. Alternatively, the FQHCs and the State may mutually agree to a different payment system. (As of January 1, 2001, this term and condition is no longer applicable.)

d. A detailed description, and plan for implementing any State supplemental payment to FQHCs (and other providers, if applicable) must be submitted to HCFA for review and approval. (As of January 1, 2001, this term and condition is no longer applicable.)

5. Traditional Providers

a.* A large proportion of the State=s Medicaid population currently receives primary care through traditional providers. In order to ensure access and continuity of care for beneficiaries who rely on these providers, the State shall encourage all MCOs qualified to serve Medicaid beneficiaries eligible for The Partnership Plan to include, in their networks, providers that have traditionally served the Medicaid population. ATraditional providers≅ include safety-net hospitals, community health centers and others. As part of its pre-implementation and on-going review of access and capacity under The Partnership Plan, to ensure beneficiary access to care and quality of services, HCFA will consider the extent to which participating MCOs have included traditional providers in their networks.

b. Provisions for facilitating the transition of traditional providers to managed care, as part of the Community Health Care Conversion Demonstration Project, are included in Attachment J.

c.* The operational protocol shall provide a description of any special measures that will be taken by the State to transition public hospitals and hospitals eligible for a high need adjustment under the State=s Health Care Reform Act of 1996 to a managed care environment under the Partnership Plan. A discussion of how beneficiaries who are currently being served by public hospitals and hospitals eligible for a high need adjustment under the State=s Health Care Reform Act of 1996 will receive Partnership Plan-required services if these hospitals are not included in MCO networks must also be included.

6. Family Planning

a. The State shall ensure that all Partnership Plan enrollees have access to, and are adequately informed of their right to access family planning services, including services provided by non-MCO network providers. The State shall monitor out-of-plan utilization of family planning services, and shall ensure that timely, appropriate care is provided to Partnership Plan enrollees.

b. All MCOs must permit Partnership Plan enrollees direct access to any family planning provider, including Title X providers. With respect to FHPlus, enrollees will be required to access family planning services within the network of their MCOs. FHPlus enrollees in MCOs that do not offer family planning services must access family planning services through separate contractural arrangements made by the State, and the State must ensure that enrollees are adequately informed on access to family planning services.

c.* The operational protocol will include a description of how confidentiality and unrestricted access to family planning services will be guaranteed under The Partnership Plan. In addition, a description of how Partnership Plan enrollees will access family planning services (including how enrollees, particularly adolescents, will be informed of their right to self-refer to non-network providers), provisions for coordinating care received out-of-network, and how, and by whom, reimbursement will be made to non-network providers, must be included in the protocol.

7. Health Services to Native American Populations

a.* In the protocol, the State shall submit to HCFA a plan, developed in consultation with the Indian tribes and/or representatives from the Indian health programs located in participating counties and boroughs, for patient management and coordination of services for Medicaid-eligible Native Americans. (For purposes of this term and condition, AIndian health programs≅ are defined as programs operated by the Indian Health Service (IHS); operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS under the authority of the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638; operated by an urban Indian organizationp ursuant to a grant or contract with the IHS under the authority of title V of the Indian Health Care Improvement Act, Pub. L. 94-437; or operated by tribes or nations that are recognized by the State either by treaty or State law.) The plan shall include: 1) mechanisms and procedures for Indian health programs to receive Medicaid reimbursement for services provided to Medicaid-eligible Native American beneficiaries receiving care through Indian health clinics; 2) mechanisms and procedures to ensure Medicaid coverage and payment of services provided to Medicaid-eligible Native Americans who are referred by Indian health programs to private providers, or who receive emergency services from private providers; 3) information to be included in the enrollment packet explaining the voluntary enrollment options for Medicaid-eligible Native

Americans; and 4) a monitoring protocol to assess the impact of The Partnership Plan on health service delivery to Native Americans. The State shall submit, on an annual basis, program enrollment data for this population, and shall make these data available to the Indian health programs upon request.

In recognition of the State's ongoing efforts to develop an implementation plan in conjunction with the Indian tribes and/or representatives of the Indian Health Programs located in participating counties and boroughs, the State is not required to submit a complete implementation plan as part of the operational protocol for The Partnership Plan.

b. With respect to FHPlus, the above condition shall apply with the exception that the benefit package shall consist only of services provided or arranged directly by the MCO.

E. QUALITY ASSURANCE

1. Encounter Data

a.* The State shall define a minimum data set (which includes at least inpatient and physician services) for all MCOs to submit, and shall make the required encounter data available to HCFA or its designated evaluation contractor. The recommended minimum data set is attached. The State shall also submit, to HCFA or its designated contractor, paid claims associated with fee-for-service window periods (i.e., periods during which mandatory populations are not enrolled in managed care), and paid claims data for out-of-plan and wrap around service utilization, both for current Medicaid beneficiaries and Home Relief recipients who are being served under The Partnership Plan. The State shall have provisions in its MCO contracts requiring MCOs to provide encounter data for all Partnership Plan enrollees and shall be authorized to impose financial penalties if accurate data are not submitted in a timely fashion. As part of the protocol, the State shall define its proposed minimum data set and present a work plan showing how collection of plan encounter data will be implemented and monitored, and the resources that will be assigned to this effort. If the State fails to provide accurate and complete encounter data, it will be responsible for providing, to the designated HCFA evaluation contractor, data abstracted from a statistically valid sample of medical records that are comparable to the required encounter data. Multiple systems (in addition to encounter data) may be utilized for report generation and data analysis.

b.* The State, in collaboration with MCOs, and other appropriate parties, will develop, and submit for approval, a detailed plan for using clinical/administrative data, including encounter/claims data, to pursue health care quality improvement prior to beginning enrollment activities. At a minimum, the plan shall include: how the baseline for comparison will be developed, which indicators of quality will be used to determine if desired outcomes are achieved and if there are problems with quality and access, where the data will be stored, how data will be validated, how monitoring will occur, and what penalties will be incurred if information is not provided.

c.* At a minimum, The State's plan for using data to pursue health care quality improvement will describe how the data will be used to study: 1) the following special populations: SPMI adults and SED children, individuals with HIV disease, other Supplemental Security Income (SSI) beneficiaries, homeless adults and families, foster children, and other populations that may enroll on a voluntary basis; and 2) the following priority areas:

- childhood immunizations;
- prenatal care and birth outcomes;
- pediatric asthma; and
- additional clinical conditions agreed upon by HCFA and the State.

As an alternative to using the encounter database to conduct these studies, the State may propose, for HCFA=s approval, other methods for studying these populations and priority areas.

d. No later than three months after initiation of enrollment under the first phase of the program, the State will submit a plan, for HCFA approval, describing how it will validate the completeness and accuracy of the encounter data. The State will conduct annual validity studies to determine the completeness and accuracy of the encounter data collected. During annual validation studies, sufficient medical records, as determined by the State, should be audited to produce a statistically sound study, the design of which is subject to approval. (HCFA shall have the right to evaluate the adequacy of the State's sampling methodology and, if determined necessary, shall require the State to revise the methodology.) The State shall compare the utilization data from the medical records and from the system database's report using the data elements contained in the State=s minimum data set. The State and HCFA will develop a schedule to assess the completeness and accuracy of the collected encounter data. If the completeness and accuracy do not meet the agreed upon standards, the State shall develop a corrective action plan.

2. Monitoring

a.* Prior to initiation of enrollment under the first phase of the program, the State will develop a plan for monitoring the performance of MCOs under The Partnership Plan. At a minimum, the State will:

- Design and begin data collection for a study comparing patient experience, on the basis of program cost, quality, and access, across MCOs and fee-for-service arrangements. The study will compare utilization rates and overall program costs and will, to the extent reliable data are available, compare utilization rates for inpatient hospital, physician, emergency room/outpatient clinic, and key ancillary services.

- Monitor the financial performance and quality assurance activities of each contracted MCO. The State will submit copies of all financial audits and quality assessments.

b. The State will meet all applicable Federal periodic medical audit requirements for contracted MCOs participating in The Partnership Plan, as articulated in Federal regulations at 42 CFR 434.53. The State shall release the RFP for the external quality review organization (EQRO) contractor as soon as possible after waiver approval, but no later than 120 days after the protocol is approved. The RFP will be sent to HCFA for approval at least 45 days before release. The resulting contract should be sent to HCFA for review at least two weeks prior to signature. The selected contractor shall perform an annual medical audit of all participating MCOs, and shall submit the report to HCFA upon request.

The annual review specifications for the EQRO or other independent review organizations must provide for review activities at both mainstream MCOs and SNPs for individuals with HIV disease (defined as individuals who are HIV-positive, but asymptomatic, individuals with symptomatic HIV disease and individuals with symptomatic AIDS), SPMI adults, SED children, and Partnership Plan enrollees who exhaust the basic mental health package offered by the mainstream MCOs and enroll in mental health SNPs (see Attachment G). HCFA shall review and approve the review specifications of independent review organizations, if applicable, that are involved in the periodic audits of MCOs under contract with the State. Annual reviews shall also examine, in particular, the care received by individuals who are eligible for SNPs, but who are being served in mainstream MCOs, and other chronically ill populations served by mainstream MCOs.

(This term and condition only applies to EQRO RFPs released after phase in of the demonstration begins.)

c. On a periodic basis, but no less often than every 12 months, the State will monitor beneficiary access to care through comparisons of the number and types of providers available for service before implementation of the demonstration and after.

3. Client Complaint and Appeal Procedures

a.* All beneficiaries must be informed of their right to file complaints, whether oral or written, appeals, and State Fair Hearings. The State must assure that all MCOs have approved internal complaint and appeal procedures in place and that these, along with LDSS- and State-level complaint and appeal processes, are in accordance with Federal regulations on grievance procedures at 42 CFR 434.32 and with Federal Regulations on Fair Hearings at 42 CFR 431, Subpart E.

b.* The protocol shall include a description of the complaint and appeals processes that will be followed by the State, the LDSSs (where applicable), and participating MCOs under The Partnership Plan. Any subsequent changes to the approved complaint procedures shall be submitted for HCFA approval prior to implementation of such changes. At a minimum, the description of complaint and

appeals procedures must include the following elements:

- provision for an expedited complaint process in the case of complaints that are of a nature that could significantly increase the risk to the enrollee=s health;
- discussion of who (including type of position, level of professional expertise) at the State, LDSS, and/or MCO level will decide when an expedited complaint process (such as the State=s expedited complaint procedure) is appropriate and what criteria will be used in making such determinations;
- specification of any time frames in which enrollees are required to file complaints or appeals at the State, LDSS, or MCO level;
- specification of the time frames (i.e., 2 business days, 30 calendar days) in which the State and LDSS will resolve appeals;
- specification of the time frames in which MCOs will resolve and respond to complaints and appeals in each designated category of urgency;
- discussion of what appeal rights exist at the MCO level and the process for filing appeals with the MCO;
- discussion of how and at what point in the complaint or appeal process enrollees may file for Fair Hearings at the State;
- discussion of how beneficiaries will be informed of their complaint, appeal and Fair Hearing rights; and
- discussion of the circumstances under which the expedited complaint process and other complaint, appeals, and Fair Hearing processes at the State, LDSS, and/or MCO level can lead to just cause disenrollment.

c. As part of the information that the State must provide to enable HCFA to assess the operational readiness of participating counties and boroughs (see Attachment E), the State must submit documentation to demonstrate that:

- complaint, appeal and Fair Hearing processes are in place;
- adequate staffs are available at the State, LDSS, and MCO level to make appropriate determinations within the required time frames;
- standardized processes are used among reviewers in making determinations; and
- procedures are in place to inform beneficiaries about how to access all available complaint, appeal, and Fair Hearing processes;

d. The State will monitor complaint and appeal processes at all levels of The Partnership Plan demonstration. The State will collect detailed data on all oral and written complaints (including complaints received through beneficiary hot lines), and appeal requests received by each contracted MCO, by LDSS or enrollment broker offices, and by personnel at the State level, including data on complaints sent through the expedited complaint process. The State will compile data on complaints, appeals, and State Fair Hearings by category of problem, where the complaint/appeal/Fair Hearing was filed, resolution time, outcome, and what if any corrective action was taken. It will report such data in summary form to the HCFA Project Officer on a quarterly basis as part of the required quarterly reports discussed in Section VI on General Reporting Requirements. The summary data will include information on the monthly number of complaints, appeals, and Fair Hearings which resulted in MCO just cause disenrollments by plan.

e. Complaint and appeals processes must be accessible to all Partnership Plan enrollees, including the disabled, the vision and hearing impaired, and non-English speaking enrollees.

f. The State will develop and submit for separate HCFA review and approval a set of complaint and appeal procedures that meet the needs of Special Needs Plan (SNP) enrollees as part of the milestone approach to the development of SNPs for clients with HIV/AIDS and serious mental illness described in Attachment H. These procedures may ultimately be the same or similar to the provisions outlined above.

IV. MMIS SYSTEMS

A.* The State shall require all MCOs to provide encounter data in a format compatible with the State's MMIS. The State will test to assure that the MCO's data is compatible with the MMIS prior to enrolling beneficiaries into the MCO. Linkages with the MMIS data using beneficiary identifiers will be acceptable rather than assuring each MCO's encounter format is compatible with the MMIS.

B.* Prior to enrolling beneficiaries in any designated phase of the phase-in plan, the State will submit evidence that a management information system is in place which meets minimum standards of performance regarding:

- monthly tracking of beneficiary enrollment and disenrollment in MCOs;
- beneficiary assignments to MCOs;
- capitation payments to MCOs;
- payments made for carve-out services provided on a fee-for-service basis and;
- other systems capabilities essential to the administration of The Partnership Plan.

C. If the State wishes to use The Partnership Plan program as an opportunity to retool its MMIS system and participate in the Medicaid Statistical Information System (MSIS) project, HCFA will provide the necessary technical assistance.

V. GENERAL PROGRAM REQUIREMENTS

A.* The LDSS= (and in the case of Family Health Plus, the State's) contracts with MCOs must include provisions for protecting the confidentiality of all demonstration-related information that identifies individuals. The provisions must specify that such information is confidential and that it may not be disclosed directly or indirectly except for purposes directly connected with the conduct of the demonstration or the administration of the Medicaid program, including evaluations conducted by the independent evaluator selected by the State and/or HCFA, or evaluations performed or arranged by State agencies. Informed written consent of the individual must be obtained for any other disclosure.

B.* All contracts and subcontracts for services related to The Partnership Plan demonstration must provide that the State agency and the U.S. Department of Health and Human Services may: (1) evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed and (2) inspect and audit any financial records, including reimbursement rates, of such contractor/subcontractors.

C. HCFA may suspend or terminate any demonstration in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with the terms of the demonstration. HCFA will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. HCFA reserves the right to withhold waivers pending or to withdraw waivers at any time if it determines that granting or continuing the waivers would no longer be in the public interest. If the waiver is withdrawn, or the demonstration terminated, HCFA will be liable for normal close-out costs only.

D. The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify HCFA in writing of the reasons for the suspension or termination, together with the effective date. If the waiver is withdrawn, HCFA will be liable for normal close-out costs only.

E. HCFA will contract with an independent contractor to evaluate the demonstration. The State agrees to cooperate with the evaluator, at no cost, by responding in a timely manner to requests for interviews, providing access to records, and sharing data, including the claims, encounter, and eligibility files. The State has the right to review reports and the right to comment on reports prepared by the evaluator.

VI. GENERAL REPORTING REQUIREMENTS

A. Within 3 months of initiation of enrollment under the first phase of the phase-in plan, the State will develop, and submit for HCFA approval, a plan for collecting the following information for Partnership Plan participants enrolled in MCOs and SNPs, at least annually, either through a beneficiary survey or other means, other data sources, or a combination of both:

- beneficiary satisfaction with services provided (including enrollment services), and access to primary care and specialty services;
- average waiting time for appointments, including physician office visits;
- average time and distance to reach providers;
- use of out-of-plan services, including use of emergency rooms;
- coordination of benefits with other health programs; and
- the number of, and causes for, disenrollment from contracted MCOs.

The State=s initial approach for collecting these data, as specified in the plan submitted to HCFA, may be modified in later years of the demonstration. The State must submit any modification requests to HCFA for approval.

B. Within 9 months of initiation of enrollment under the first phase of the phase-in plan, the State will conduct a statistically valid sample survey of participating MCO providers. At a minimum, the survey will measure provider satisfaction with reimbursement, administrative elements, communication, and coordination of care with linkage providers.

C. The information described in (VI)(A) above, and results of the provider survey will be provided to HCFA by the end of the first operational year, for individuals enrolled during the year. Thereafter, the State will provide the survey results and the above information by the ninth month of each operational year. The contents of the provider survey, and beneficiary survey, if applicable, as well as the survey and sampling methodologies, must be approved by HCFA prior to conducting the survey(s). The State will require a corrective action plan for contracted MCOs that score below a stipulated minimum level in beneficiary satisfaction and will monitor implementation of the corrective action plan. The minimum beneficiary satisfaction level must be specified in the operational protocol.

D. On an annual basis, the State shall submit Form HCFA-416, EPSDT program reports for the previous Federal fiscal year. These reports will follow the format specified in section 2700.4 of the State Medicaid Manual, with data for each line item arrayed by age group and basis of eligibility. The State must comply with any future changes adopted by HCFA regarding the reporting of EPSDT data.

E. During the phase in of mandatory enrollment under the demonstration, the State will submit monthly data reports, which are due 20 days after the end of each calendar month, and have monthly conference calls with HCFA. The monthly data reports are to include the following information, by county and by MCO: number of new enrollments for the

period, and total enrollment to date, exemptions requested and granted, transfers to another MCO, disenrollments permitted to the fee-for-service system, number of auto assignments, and number of hot line calls. HCFA reserves the right to request additional information in the monthly reports on issues where problems or concerns have been identified in the phase-in process. For FHPlus, the reports shall contain all of the above-listed information with the exception of exemptions, disenrollments into fee-for-service, and number of auto-assignments.

F. The State will submit quarterly progress reports, which are due 60 days after the end of each quarter. The reports should include a discussion of events occurring during the quarter that affect health care delivery, including but not limited to: enrollment and outreach activities; default assignments; disenrollments; quality of care; access; MCO financial performance; grievances; beneficiary hotline performance; benefit package (including carve outs and out-of-plan services); and other operational issues. The report should include a separate discussion of State efforts related to the collection and verification of encounter data. The report should also include proposals for addressing any problems identified in the quarterly report. Guidelines for quarterly reports are in Attachment L. With respect to FHPlus, the reports will contain all of the above-listed information with the exception of default assignments.

G. The State will submit a draft annual report documenting accomplishments, demonstration status, quantitative and case study findings, and policy and administrative difficulties no later than 120 days after the end of its operational year. Within 60 days of receipt of comments from HCFA, a final annual report will be submitted.

H. At the end of the demonstration, a draft final report should be submitted to HCFA for comments. HCFA's comments must be taken into consideration by the State for incorporation into the final report. The State should use HCFA, Office of Research and Demonstrations' Author's Guidelines: Grants and Contracts Final Reports in the preparation of the final report. The final report is due no later than 90 days after the termination of the demonstration.

I. The State will submit a demonstration phase-out plan to HCFA 6 months prior to initiating normal phase-out activities or, if section 1115 demonstration authority is extended by HCFA, an extension plan to keep the demonstration operating. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergency circumstances. Any phase-out plan or extension plan is subject to HCFA review and approval.

Attachment A

General Financial Requirements

1. The State shall provide quarterly expenditure reports using the Form HCFA-64 to separately report expenditures for services provided under the Medicaid program and those provided through The Partnership Plan under section 1115 authority. HCFA will provide Federal Financial Participation (FFP) only for allowable Partnership Plan expenditures that do not exceed the expenditure limits as specified in Attachment B.

2. a. In order to track expenditures under this demonstration, the State will report Partnership Plan expenditures through the Medicaid Budget and Expenditure System (MBES), following routine HCFA-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual, except as discussed below. Expenditures subject to the budget neutrality limit (described in Attachment B) will be differentiated from other Medicaid expenditures by identifying them on separate Forms HCFA-64.9 and/or 64.9p, with the demonstration project number assigned by HCFA (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made) shown on the forms. For monitoring purposes, cost settlements attributable to expenditures subject to the budget neutrality cap must be recorded on Line 10.b, in lieu of Lines 9 or 10.c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual. The term, Aexpenditures subject to the budget neutrality cap,≅ is defined in Attachment I, item 4. Expenditures related to the programs listed in Attachment J, item 1 shall be reported each quarter on separate Forms HCFA-64.9 and/or 64.9p apart from other expenditures subject to the budget neutrality limit.

   b. The costs of protease inhibitor (PI) drugs and viral load testing services shall be counted as an expenditure subject to the overall expenditure limit (described in Attachment B)of the New York Partnership Plan demonstration. However, HCFA recognizes that the net cost of protease inhibitors may place an onerous burden on the State that is not accounted for in the calculation of the budget neutrality expenditure limit. Based on a study of the net costs, HCFA will adjust the without-waiver budget neutrality baseline in all five years of the demonstration, as appropriate.

   Specifically, HCFA will make appropriate retrospective and prospective adjustment of annual budget estimates for the net cost of PI services. HCFA believes that New York has a data system that permits the necessary analysis. Using service utilization and the drug therapy data from Years 1 and 2 of the demonstration, the State shall submit a report to HCFA on the net Title XIX cost of PI therapy for the treatment of HIV and AIDS patients. The net cost analysis of protease inhibitor therapy shall include the direct costs of protease inhibitor

therapy, and the estimated impact of protease inhibitor therapy on the cost of other drug therapies and on other chronic and acute care service utilization. Following receipt of the State=s report, HCFA will consider an appropriate adjustment to the overall expenditure limit, which may include retrospective adjustment to the budget estimates for Years 1 and 2.

c. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are attributable to the demonstration. Procedures regarding the tracking and reporting of administrative costs will be described in the Operational Protocol, to be submitted by the State to HCFA under terms specified in Attachment C.

d. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures, if the expenditures are subject to the provisions of Section 1132. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the 1115 demonstration on the Form HCFA-64 in order to properly account for these expenditures in determining budget neutrality.

e. The procedures related to this reporting process will be detailed in the Operational Protocol.

3. a. For the purpose of calculating the budget neutrality expenditure cap described in Attachment B, each calendar quarter the State shall provide to HCFA the actual number of eligible member/months (as defined in 3.b) for Partnership Plan current eligibles in each of the Medicaid eligibility groups (MEGs) listed in Attachment I, and for CHIP eligibles (see 3.c below). The State must report eligible member/months for CHIP eligibles beginning the date the demonstration is approved, and for the other MEGs according to the phase-in schedule in Attachment B. Preliminary eligible counts will be provided to HCFA within 30 days after the end of each quarter. Final eligible counts will be provided to HCFA within 120 days after the end of each quarter. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY shall be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversaries of that day.) Procedures for reporting eligible member/months shall be defined in the Operational Protocol. Eligible member/months will be reported only for CHIP eligibles for whom the cost of CHIP coverage has been submitted for Title XIX matching as a cost not otherwise matchable under the 1115 demonstration, and from which the Federal share is used to fund CHCCDP under terms specified in Attachment J.

b. The term, Aeligible member/months,≅ shall refer to the number of months in which persons are eligible to receive services under Medicaid. For example, a person who is eligible for three months contributes three eligible member/months to the total. Two individuals who are eligible for two months together contribute four eligible member months to the total.

c. Definitions of the terms, APartnership Plan current eligibles,≅ APartnership Plan expansion eligibles,≅ ACHIP eligibles,≅ and "Family Health Plus expansion eligibles" are given in Attachment I.

4. The standard Medicaid funding and reporting processes will be used during the demonstration. New York must continue to estimate matchable expenditures for the entire program (including the State plan and the Partnership Plan) on the quarterly Form HCFA-37. The State must provide supplemental schedules that clearly distinguish between estimates of expenditures subject to the budget neutrality cap (by major component) and estimates of expenditures that are not subject to the cap. HCFA will make Federal funds available each quarter based upon the State's estimates, as approved by HCFA. Within 30 days after the end of each quarter, the State must submit the Form HCFA-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. HCFA will reconcile expenditures reported on the Form HCFA-64 with Federal funding previously made available to the State for that quarter, and include the reconciling adjustment in a separate grant award to the State.

5. HCFA will provide Federal Financial Participation (FFP) at the applicable Federal matching rate for the following, subject to the limits described in Attachment B:

a. Administrative costs, including those associated with the administration of The Partnership Plan;

b. Net expenditures and prior period adjustments which are paid in accordance with the approved State plan (including disproportionate share hospital payments); and

c. Net medical assistance expenditures made under Section 1115 and 1915 waiver authority, including those made in conjunction with the Partnership Plan demonstration (including Medical Assistance expenditures for Home Relief adults and programs listed in Attachment J, item 1), subject to the limits set forth in Attachments B, I and J. Federal matching payments shall not be provided for the medical care coverage costs for CHIP eligibles or FHPlus eligibles to the extent that the costs are financed through premiums paid by the eligibles themselves or their families. Furthermore, Federal matching payments for CHIP expenditures may not exceed $250 million in any given demonstration year.

d. Beginning with the approval date of the demonstration, the State may claim Federal matching payments on expenditures for the State-only programs listed in Attachment J, item 1, to the extent that the funds are used for payments to hospitals under CHCCDP. All such matching funds are subject to the budget

neutrality limit. CHIP expenditures may be claimed for the cost of CHIP coverage provided on or after the date in which the demonstration is approved.

e. The State shall claim no more than $250 million in Federal matching funds in any demonstration year for the programs listed in Attachment J, item 1. The period between date of approval and date of implementation, described in item d above, shall be counted as part of the first demonstration year for this purpose. Should costs totaling more than $500 million (corresponding to $250 million Federal share) be incurred by these programs during any demonstration year, HCFA will not provide Federal match for claims in excess of $500 million. The State may submit claims for expenditures in excess of $500 million incurred in a single year as expenditures in a subsequent year, consistent with item 2.d above and subject to Section 1132 of the Act. Expenditures submitted in subsequent years will be subject to all applicable limitations under Title XIX and associated regulations effective at the time the expenditures are made (not at the time in which Federal matching funds are claimed). With respect to expenditures for programs listed in Attachment J, item 1, the State shall not exercise its rights to claim interest under the Cash Management Improvement Act.

f. With respect to the amounts recognized for Federal match in Attachment J, item 1, annual claiming limits established in these terms and conditions shall only apply to claims made pursuant to this demonstration.

6. The State will certify that State/local monies used as matching funds for Partnership Plan purposes will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

7. The State shall continue to submit form HCFA-2082 in hard copy. However, if the State elects, and is accepted by HCFA to participate in the Medicaid Statistical Information System (MSIS), the State may be exempt from the requirement for filing the hard copy 2082. Form HCFA-2082 summarizes Medicaid eligibility and expenditure information for the Federal Fiscal Year (October 1 through September 30). (Section 2700 of the State Medicaid Manual details the requirements for reporting on the HCFA 2082). This form must include all individuals that received services through the State Medicaid program, including expanded eligibility groups covered under the section 1115 demonstration. These groups should be included in Maintenance Assistance Status APoverty Related,≅ with the appropriate Basis of Eligibility.

The State must also submit an additional HCFA-2082 that provides eligibility counts and expenditure data for the expanded eligibility groups, i.e. those groups which include individuals eligible solely because of the demonstration. When completing the additional 2082, submit Sections A, B, C, D, and K.

Attachment B

Budget Neutrality

The following describes the method by which budget neutrality will be assured under the New York State Partnership Plan Demonstration. New York will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. Each annual estimate shall be the sum of two components: an estimate of medical assistance expenditures for persons eligible for Medicaid under the current State plan participating in the demonstration (including those that could have made Medicaid eligible under э 1902(r)(2) of the Social Security Act; i.e., CHIP eligibles, and uninsured parents under FHPlus as of the implementation date for FHPlus.), and an estimate of disproportionate share hospital (DSH) expenditures. The annual estimates will then be added together to obtain an expenditure estimate for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures described below. For each DY, the Federal share will be calculated using the Federal medical assistance percentage (FMAP) rate(s) applicable to that year.

Projecting Service Expenditures

The annual estimates of Medicaid service expenditures will be performed using a per capita cost methodology. In this way, New York will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, HCFA will not place New York at risk for changing economic conditions. However, by placing New York at risk for the per capita costs of Medicaid eligibles, HCFA assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

Each annual estimate of Medicaid service expenditures will be calculated as the sum of separate cost projections for each of MEGs defined in Attachment I, and for CHIP. The annual cost projection for each MEG and for CHIP will be the product of the projected per member/per month (PMPM) cost for that MEG (or CHIP), times the actual number of eligible member/months as reported to HCFA by the State under the guidelines set forth in Attachment A. The annual estimates for CHIP will be subject to an additional limit, which is described below.

Projecting PMPM Cost

Projected PMPM cost for each MEG will be calculated by using a pre-determined set of *trend factors* (given below) to convert *base year* per capita costs into current year projected per capita costs for each year of the demonstration.

Base year

The State shall submit to HCFA a base year PMPM cost for each MEG and for CHIP, subject to the approval of the Project Officer. The base year for projecting service expenditures for all MEGs except FHPlus parents shall be State fiscal year (SFY) 1996 (April 1, 1995 to March 31, 1996). Base year PMPM costs figures shall be submitted to HCFA no later than December 31, 1997. If final base year PMPM costs are not submitted to HCFA by December 31, 1997, HCFA reserves the right to use estimated PMPM costs for the purpose of the budget neutrality calculations pending submission of final PMPM costs by the State and approval by the Project Officer. In the case of FHPlus, the base year PMPM for FHPlus parents shall be calculated based upon Medicaid fee-for-service expenditures for a comparable population for federal fiscal years FFYs 1998 and 1999 (October 1997 through September 1999). Adjustments will be made to reflect the difference between the Medicaid benefit package and the FHPlus benefit package, and to reflect the expected level of managed care savings. Base year PMPM cost figures for FHPlus parents shall be submitted to HCFA no later than September 30, 2001. If final base year PMPM costs for FHPlus parents are not submitted by September 30, 2001, HCFA reserves the right to use estimated PMPM costs for the purpose of budget neutrality calculations pending submission of final PMPM costs by the State and approval by the Project Officer. Once the State has passed welfare reform legislation, the State and HCFA agree to reevalaute the MEGs that will be used to monitor the waiver. If it is agreed that revisions are necessary in the MEGs, the State with HCFA's approval will recompute the base year PMPMs for the new MEG.

<u>The base year PMPM costs must conform to the following requirements</u>.

The base year PMPM cost for each MEG except FHPlus parents shall be computed by dividing the total Medicaid expenditure for Medicaid eligibles in that MEG by the number of eligible member/months for that MEG. Only eligible member/months and service expenditures related to persons who would have been Partnership Plan current eligibles if the demonstration had been in existence in SFY 1996, shall be counted for the purpose of calculating base year PMPM costs. The term, APartnership Plan current eligibles≅ is defined in Attachment I, Item 1.

The base year PMPM costs must reflect all expenditures (and only those expenditures) described in Attachment I, Item 2.

The base year PMPM cost must include an adjustment for any Medicaid budget cuts that were included in the State's FY 1997 budget, as well as for State plan amendments 97-01 and 97-07 (if the latter are eventually approved by HCFA). At HCFA's request, the State will submit a proposed method for adjusting base year PMPM costs, subject to HCFA approval.

The PMPM cost shall include an adjustment for the estimated cost of expenditures for School Supportive Targeted Case Management Services, which prior to the demonstration period were considered administrative costs and therefore were not included in the base year data.

The PMPM cost shall include an adjustment for the estimated costs of expenditures to FQHCs resulting from the state's compliance with the Federal Balance Budget Act of 1997.

A separate base year PMPM cost will be calculated for CHIP, which will consist of the base year PMPM cost for the MA-AFDC, and AFDC-related, Under 21 MEG, adjusted to remove xpenditures for services covered under Medicaid but not covered through CHIP.

The State's submission of base year PMPM costs shall be accompanied by a description of the methodology used to compute the base year PMPM costs.

Phase-in

The budget neutrality limit will be implemented in three phases:

- Expenditures for the programs listed in Attachment J, item 1 will be subject to the budget neutrality limit beginning with the date of approval of the demonstration. Calculation of the CHIP component of the budget neutrality limit will begin at this time. Until the demonstration is implemented (defined as the day in which managed care enrollment becomes mandatory under 1115 waiver authority for any current Medicaid eligible in any part of the State), the CHIP component will be the only component of the budget neutrality limit that is implemented.

- **Starting the day the demonstration is implemented, expenditures for all Partnership Plan current eligibles in the Aid to Families with Dependent Children (AFDC) and AFDC-related MEGs will be subject to the budget neutrality limit. Simultaneously, expenditures for Home Relief Adults will become matchable, and will also be subject to the budget neutrality limit. Starting the day FHPlus is implemented, expenditures for all FHPlus eligibles are matchable and subject to the budget neutrality limit.** Between the initial implementation date and the beginning of mandatory managed care for SSI and MA-SSI Partnership Plan current eligibles, the budget neutrality limit will consist of the CHIP component, the AFDC and AFDC-related MEGs, the FHPlus parents' MEG and the DSH component.

- At the point in which SSI and MA-SSI Partnership Plan current eligibles begin mandatory enrollment into managed care under the 1115 demonstration in any part of the State, expenditures for all SSI and MA-SSI Partnership Plan current eligibles will be subject to the cap, and the budget neutrality cap will reflect costs related to SSI and MA-SSI Partnership Plan eligibles from that point forward.

Trend Factors

The following table gives the specific trend factors that will be used to project per member/per month (PMPM) costs for each year of the demonstration. Except for the trends for FHPlus parents, these are past trends in PMPM cost by eligibility category, based on New York State=s historical Medicaid expenditure and eligibility data for the Federal fiscal year (FFY) 1990 through 1994 period, submitted by the State in August, 1995. The trends rate for FHPlus parents will be the same as the trend rate for the MA-AFDC and AFDC Adults, the populations which most closely resemble the FHPlus parent population. The first column shows the annual percentage trends in PMPM cost on a Federal fiscal year basis for each of the eight MEGs. The

second column shows the monthly equivalent trend factors that correspond to the annual trend factors in the first column. The latter will be used to convert SFY PMPM cost estimates to DY estimates. The trend factors for the MA-AFDC, and AFDC-related, Under 21 MEG will be used to project PMPM expenditures for CHIP.

	Annual trend factors	Monthly trend factors
Eligibility Category		
SSI, 65 Years and Over	6.3%	0.5104%
SSI, Under Age 65	5.3%	0.4313%
AFDC, Age 21 – 64	5.1%	0.4154%
AFDC and AFDC-related, Under Age 21	9.6%	0.7668%
MA-SSI, 65 Years and Over	6.3%	0.5104%
MA-SSI, Under Age 65	5.3%	0.4313%
MA-AFDC, Age 21 - 64	5.1%	0.4154%
FHPlus Parents	5.1%	0.4154%

Using the trend factors to produce non-Federal fiscal year PMPM cost estimates

Because the beginning of the demonstration is unlikely to coincide with the beginning of either the Federal or State fiscal year, the following methodology will be used to produce DY estimates of PMPM cost for the first demonstration year. Using the monthly equivalent trend factors shown above, the appropriate number of monthly trend factors will be used to convert SFY 1996 base year PMPM costs to PMPM costs for the first DY. After the first DY, the annual trend factors shown above will be used to trend forward from one DY to the next. (This procedure is described more fully in the sample calculations presented below.)

Sample Calculations

First Demonstration Year:

As an example, assume that the base year (SFY 1996) per capita cost for the AFDC, Age 21-64 MEG is $206.66, and the first year of the demonstration (DY 1998) is the year beginning 5/1/97 and ending 4/30/98. DY 1998 is twenty-five months in time beyond SFY 1996, therefore, twenty-five months of trend factor must be applied to trend SFY 1996 cost forward to DY 1998. Applying twenty-five months of trend factor at 0.3675% per month results in a DY 1998 estimated PMPM cost of $226.51. ($226.51 = $206.66 X $(1.003675)^{25}$)

Removing 1915(b) Managed Care Savings From AFDC and Related PMPM Cost Estimates

Should the State implement the 1915(b) Medicaid managed care program in 31 counties prior to the implementation of the Partnership Plan 1115 demonstration, estimated without-waiver costs for AFDC and AFDC-related Partnership Plan current eligibles must be adjusted downward to remove projected savings attributable to the 1915(b) program. Projected PMPM costs for the AFDC and AFDC-related population will be adjusted downward using the following formula:

(adjusted PMPM cost) = (unadjusted PMPM cost) X [1-SAV X SHARE]

In the above formula, **SAV** is the estimated PMPM savings for AFDC and AFDC-related beneficiaries in 1915(b) managed care, and **SHARE** is the ratio of two factors: (1) **MCMM**, the number of managed care member/months that will occur in the 31 counties between the start of implementation of the 1915(b) program and the start of implementation in applicable counties under 1115, up to one year following the initiation of 1915(b); and (2) **AFDCMM**, total AFDC and AFDC-related member-months experienced Statewide during the year following implementation of the 1915(b) program. By December 31, 1998, the State shall submit to HCFA all information needed to calculate the adjustment factor described above.

Limits on Annual Estimates for CHIP

In order to calculate the budget neutrality limit for CHIP for the period between approval of the 1115 demonstration and its implementation, a PMPM cost estimate must be calculated for the Ademonstration year≅ prior to the implementation of the demonstration, using the methodology described above. For example, if the demonstration were to begin on October 1, 1997, the CHIP PMPM cost estimate used for the period between approval and implementation would be the estimated cost for the year beginning 10/1/96 and ending 9/30/97.

For CHIP and FHPlus eligibles who are subject to premium cost sharing, an adjustment must be made to the PMPM cost estimates so that they reflect the total cost net of premium of serving CHIP and FHPlus eligibles. The adjustment will be performed using the same methodology that is used to determine the amount of premium cost sharing that eligibles must pay. (For example, if at a given point in time the amount of premium cost sharing for a group of CHIP eligibles was defined as 5% of the total monthly cost of coverage, then the PMPM cost estimate for that group of CHIP eligibles would be reduced by 5%.)

If in any DY the total Federally matched expenditure for CHIP should exceed the amount needed to generate $250 million in Federal matching funds, the annual estimate for CHIP shall be no greater than $250 million) FMAP, where FMAP is the Federal Medical Assistance percentage applicable to that DY. Should the FMAP rate for New York change during the course of the DY, an appropriate weighted average FMAP will be used for this calculation.

Projecting DSH Expenditures

The projected annual DSH expenditures for the demonstration will be calculated using an aggregate cost method, in which a base year aggregate cost figure is grown using a predetermined trend factor.

Base year

The base for DSH will be the lower of: (1) actual DSH expenditures in SFY 1996 (i.e., DSH payments subject to the SFY 1996 hospital specific DSH limits), or (2) $3,035,699,500, which is the average of the Federal fiscal year (FFY) 1995 and 1996 DSH allotments.

Trends

A single average annual trend factor of 4.5% (0.3675% monthly equivalent) will be used to project DSH expenditures in the absence of the demonstration. This trend factor is the average trend from the DSH component of the FY 1997 President=s Budget Medicaid Baseline Forecast, averaged over the period between SFY 1996 and the anticipated final DY (based on an assumed demonstration start date of 10/1/97). If the start of the Partnership Plan demonstration is delayed beyond 12/31/97, the trend factor will be recalculated. The methodology for using this trend factor to calculate DY DSH expenditure estimates from the SFY 1996 base year total will be the same as the one outlined above for use in projecting service expenditures.

Taxes and Donations

If any health care related tax which was in effect during the base period, or provider related donation that occurred during the base year, is determined by HCFA to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act, HCFA reserves the right to make adjustments to the budget neutrality cap.

How the Limit Will Be Applied

The limit calculated above will apply to actual expenditures, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to HCFA. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be prorated based on the time period through the termination date.

Expenditure Review

HCFA shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later that six months after the end of each demonstration year, the HCFA will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. If the State exceeds the cumulative target, they shall submit a corrective action plan to HCFA for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
Year 1	Year 1 budget neutrality cap plus	8 percent
Year 2	Years 1 and 2 combined budget neutrality cap plus	3 percent
Year 3	Years 1 through 3 combined budget neutrality cap plus	1 percent
Year 4	Years 1 through 4 combined budget neutrality cap plus	0.5 percent
Year 5	Years 1 through 5 combined budget neutrality cap plus	0 percent

Attachment C

Operational Protocol

The State will be responsible for developing a detailed protocol describing The Partnership Plan demonstration. The protocol will be a stand-alone document that describes all operational policies and administrative procedures in the demonstration. The protocol will be submitted to HCFA for approval after The Partnership Plan demonstration is approved. Within 30 days of receipt of the protocol, HCFA will identify, in writing, all significant issues that are to be addressed by the State, and will work with the State toward approval of the final protocol document within 60 days. This 60-day period does not include the period in which the State is responding to HCFA=s written comments and questions on the protocol. The State shall assure and monitor compliance with the protocol. The time frames listed above apply to any protocol revisions related to FHPlus. The protocol revisions must be submitted to HCFA within 30 days from the date the State receives the official letter transmitting the terms and conditions for FPLus. The protocol will include sections on all the elements specified below, and those identified throughout this document:

1. The agencies involved in administering the demonstration (City, State and County), and their responsibilities, functions, and organizational structure. (With respect to FHPlus, the State agencies and their responsibilities, functions, and organizational structure. If applicable, please discussion any deviations which may exist between counties.)

2. A complete description of the populations eligible for the demonstration, both on a mandatory and voluntary basis. In addition, any exemption provisions should be described, e.g., the State intends to exempt individuals with chronic medical conditions who are being treated by physicians who are not part of any MCO network until their course of treatment is completed. The protocol must include a definition of "chronic medical conditions," and the process for identifying and exempting individuals with chronic medical conditions from managed care enrollment.

3. A description of how special populations will be served under The Partnership Plan program, including, but not limited to: foster children, the dually eligible, and individuals with developmental disabilities; a description of how homeless populations (adults and families) will access health care services under the demonstration (this should include a description of how providers of care for the homeless will be incorporated into the managed care model and reimbursed for their services to this population). The discussion should also include any special provisions for other eligibility groups that may enroll on a voluntary basis, e.g., home and community-based waiver participants.

4. A description of how presumptively eligible pregnant women will be served under The Partnership Plan program.

5. A complete description of Medicaid services covered under The Partnership Plan, specifying those that are the responsibility of the MCOs, and those for which the State

retains responsibility. This shall include a complete description of the extended family planning benefit package for women who lose eligibility 60 days post partum.

6. A description of all linkage agreement requirements (including that of non-network providers) and a plan for coordinating the primary and specialty care of special needs populations.

7. A detailed plan for ensuring that the full range of EPSDT services, including outreach and preventive care, are provided by MCOs participating in The Partnership Plan program, and for ensuring compliance with EPSDT reporting requirements.

8. A description of how confidentiality and unrestricted access to family planning services will be guaranteed under The Partnership Plan. In addition, a clear description of how Partnership Plan enrollees will access family planning services (including how enrollees will be informed of their right to self-refer to non-network providers), provisions for coordinating care received out-of-network, and how, and by whom, reimbursement will be made to non-network providers. With respect to FHPlus, include a description of how enrollees whose MCO does not provide family planning services will be notified how to access family planning services.

9. A description of the State=s policies with regard to MCO drug formularies. In addition, a description of the process for monitoring the adequacy of a MCO=s drug formulary must be included.

10. A description of how the State will ensure that disruptions in care do not occur for persons who exhaust their basic alcoholism and substance abuse benefits and are referred to the Office of Alcoholism and Substance Abuse Services (OASAS) extended benefit network.

11. A complete description of the State's policy on MCO marketing, including a discussion of all permissible marketing activities and MCO marketing strategies. With respect to FHPlus, include a description of the facilitated enrollment process.

12. Description of the beneficiary education and outreach process, and the State's plan for implementing the beneficiary education and outreach activities, including any unique methods for educating and informing special needs populations about The Partnership Plan, and for addressing language or other communication barriers.

13. A comprehensive description of the enrollment and disenrollment processes for all targeted populations. This must, at a minimum, include a discussion of face-to-face enrollment counseling opportunities, the process for following up with eligible individuals to assist them in making a decision regarding choice of MCO, enrollment materials to be sent in the mail, the default assignment process, State and/or MCO Medical Assistance cards, and the content of enrollment, assignment, and exemption/disenrollment notices. The following must also be specified:

- the process for notifying eligible individuals currently voluntarily enrolled in MCOs that are not selected as Partnership Plan contractors and subsequently enrolling them in MCOs which have been qualified and selected to serve Partnership Plan participants;

- the process by which individuals who are in a mandatory enrollment category may apply for an exemption or disenrollment;

- the process for training individuals responsible for face-to-face enrollment counseling services;

- the criteria that will determine whether exemptions or disenrollments are granted;
- a complete description of the default assignment methodology;

- a description of sites where beneficiaries may seek assistance with the completion of enrollment forms;

- the time frames associated with enrollment, default assignments and disenrollments;

- the process for notifying, enrolling, and disenrolling individuals who are in a voluntary enrollment category;

- the process for subsuming existing 1915(b) Medicaid managed care programs, including the newly-approved program in 31 counties of the State, within the Partnership Plan;

- the process for ensuring that individuals with HIV disease (including individuals who are HIV-positive but asymptomatic, individuals with symptomatic HIV disease and individuals with symptomatic AIDS) have access to information regarding their options under The Partnership Plan.

- the process for ensuring that SPMI adults and SED children have access to information regarding their options under The Partnership Plan.

- A description of approaches toward continuous improvement to minimize auto-assignment rates;

- reasons for just cause disenrollment;

- good cause reasons for changes in PCPs beyond the limits specified in State law (e.g., difficulty scheduling appointments, unacceptable provider-enrollee relationships, etc.);

- grace period for changing MCOs without cause;

- lock-in policies; and

- open enrollment policies

14. The process by which the State will monitor the extent to which "churning" between the Partnership Plan and FHPlus necessitates changes in MCO enrollment, and any related disruptions in care.

15. The specific procedures and required time frames MCOs must follow to inform LDSSs of new Partnership Plan enrollees that they are unable to contact, or of any change in enrollee status (this includes a change in eligibility status, e.g., from a mandatory to a voluntary or exempt enrollment category).

16. A description of any special measures that will be taken by the State to transition public hospitals and hospitals eligible for high need adjustment under the New York State Health Care Reform Act of 1996 to a managed care environment under the Partnership Plan. A discussion of how beneficiaries who are currently being served by public hospitals will receive comparable services if these hospitals are not included in MCO networks must also be included.

17. The required content of MCO handbooks for Partnership Plan enrollees, and the required time frames for handbook distribution.

18. MCO selection policies, contracting requirements, and provider solicitation plan.

19. Procedures for providing capitation payments to MCOs and for timely notification to MCOs of new Partnership Plan enrollees and disenrollees.

20. A description of demonstration policies regarding FQHCs and Rural Health Clinics.

21. MCO financial reporting, and monitoring requirements including: (a) the ongoing plan for monitoring MCO solvency throughout the demonstration; (b) any reinsurance options the State is offering managed care contractors; and (c) contingency plans for assuring continued access to care for Partnership Plan enrollees in the case of an MCO contract termination and/or insolvency.

22. A comprehensive quality assurance monitoring plan that includes:

    - a discussion of all quality indicators to be employed and methodology for measuring such indicators (including unique indicators for special populations);

    - a plan for monitoring access to, and quality of care for individuals who are voluntarily enrolled in mainstream MCOs, and that of other special populations, including the disabled, individuals who speak languages other than English as a first language, etc. Special focus studies of these individuals can be by aid category;

- A discussion of general review activities for participating MCOs and SNPs through annual EQRO reviews and other independent reviews;

- monitoring procedures to ensure that MCOs are addressing the needs of Partnership Plan enrollees who speak languages other than English as a primary language;

- A description of the process for monitoring access to, and the provision of transportation services to and from medical care;

- survey activities to be undertaken, and the monitoring and corrective action plans to be triggered by the surveys;

- quality assurance improvement activities to be required of the MCOs;

- procedures for providing feedback on specific deficiencies, and policies for requiring corrective action;

- provider-enrollee ratios and access standards. (This shall include a detailed description of the State=s methodology for determining unduplicated PCP-to-beneficiary ratios. The methodology for this analysis should, at a minimum, take into consideration the incidence of providers affiliated with multiple MCOs. A description of how the State will assess, monitor and enforce these capacity requirements and access standards must also be included); and

- fraud control provisions and monitoring

23. A detailed plan, developed in consultation with the Indian Health Programs, for patient management and coordination of services for Medicaid-eligible Native Americans, and a monitoring protocol to assess the impact of The Partnership Plan program on health service delivery to Native Americans.

24. The proposed minimum data set, and a work plan showing how collection of encounter data from MCOs will be implemented and monitored; measures that will be in place for ensuring completeness and accuracy; what resources will be assigned to this effort; and how the State will use the encounter data to monitor implementation of the demonstration and feed findings directly into program change on a timely basis. A plan describing how the completeness and accuracy of encounter data will be validated by the State must also be included.

25. The complaint, appeal, and State Fair Hearing procedures that will be in place at the State, LDSS, and MCO levels, and the procedures for informing enrollees of them, as described in Section III.E.3.a.-f. of these terms and conditions. This section must include, among the other required elements, a discussion of the State=s planned expedited complaint process at the State and MCO levels.

26. A detailed description of the transitional supplemental payment methodology to FQHCs (and other providers, if applicable), including the provider eligibility criteria to be employed, the time period that such payments will be made available, etc.

27. Basic features of the administrative and management data system, including any specific enhancements to the system required to accommodate The Partnership Plan program, and the time frames for completion of the necessary enhancements.

28. Description of all Partnership Plan referral authorization policies, procedures, and requirements in effect under The Partnership Plan program.

29. Process employed by the State to certify MCO qualifications and readiness to serve Partnership Plan participants.

30. For FHPlus, a description of any way in which commercial insurers will be treated differently from other MCOs.

A description of any borough- or county-specific variations to the approved protocol shall be submitted as part of the required documentation for each phase of the phase-in plan, as described in Attachment E.

Attachment D

Access Standards

1. Patient Load - The State shall require that MCOs monitor the patient load of their PCPs to ensure that no PCP is assigned or selected by more enrollees than s/he can reasonable manage in their practice while maintaining access according to the standards established by the State. In general, MCOs must ensure that the PCP-to-beneficiary ratios below are maintained on a provider-specific basis for Medicaid beneficiaries. The State shall conduct focused studies to ensure that beneficiary access to services is not adversely impacted by these ratios.

Individual providers with office-based practices: - practicing with a Physician Extender	1,500 enrollees:1 PCP 2,400 enrollees:1 PCP & PE
Individual providers practicing in Article 28 comprehensive community-based primary care centers -practicing with a Physician Extender	3,000 enrollees:1 PCP 4,000 enrollees:1 PCP & PE
Individual providers with practices based primarily in Outpatient Departments of Hospitals (OPDs) -practicing with a Year 2 or 3 Resident (FTE)	2,500 enrollees:1 PCP 4,000 enrollees:1 PCP & FTE Resident

2. Time/Distance - The State shall demonstrate that provider networks are in place which guarantee all beneficiaries in urban/suburban locations access to primary care sites, specialty care and hospitals within 30 minutes/30 miles of their residence. Transport time and distance in rural areas to primary care sites and hospitals may be greater than 30 minutes/30 miles only if based on the community standard for accessing care or if by beneficiary choice. Where greater, the exceptions must be justified and documented by the State on the basis of community standards, and available for review by HCFA on request.

   Travel time/distances to all types of specialty care, including mental health, pharmacy, and lab and x-ray services shall not exceed 30 minutes/30 miles from the beneficiary=s residence except in rural areas when longer access times and distance can be justified on the basis of community standards.

2. Appointment Times - Participating MCOs shall employ sufficient medical personnel and staff to be able to meet basic standards in the scheduling of appointments with Partnership Plan beneficiaries. Appointments must be available for Partnership Plan beneficiaries in accordance with the normal practice standards and hours of operation.

   Maximum expected waiting times shall be as follows:

   - Emergency Care - Emergency care for physical and/or mental health conditions must be provided as the situation dictates. In general, MCO coverage of emergency care to treat

potentially life-threatening situations is required on a 24-hour a day, 7-day a week basis, and in the nearest provider setting, regardless of MCO affiliation.

- Urgent Care - Triage and appropriate treatment shall be provided the same or next day.

- Non-Urgent Problems and Routine Primary Care - Appointments for non-urgent care and routine primary care shall be provided within 4 weeks of client request.

MCOs must have a system in place to document compliance with the above appointment scheduling time frames. The State shall monitor compliance with appointment/waiting time standards as part of the required surveys and monitoring requirements.

3. In-Office Waiting Times - Beneficiaries with appointments shall not routinely be made to wait longer than one hour.

4. Referrals - Referral appointments to specialists shall not exceed 48 hours for urgent care or routinely exceed 30 days for routine care.

5. Providers - The State will encourage health plans serving both Medicaid and non-Medicaid populations to make their entire network available to Medicaid enrollees and will, at a minimum, assure sixty percent (60%) of the network will be available in year one of the demonstration and eighty percent (80%) in year two. The degree to which a plan proposes to open its network to Medicaid enrollees will be taken into consideration during the proposed evaluation process, and will also be an important consideration during subsequent procurements. Depending on the degree of mainstreaming achieved in the current process, the State may mandate health plans to open their entire networks during the next qualifying process.

6. Documentation

a. All entities providing care to Partnership plan enrollees must have a general system in place to document adherence to the appropriate access standards (e.g., physician waiting times and appointment times). The State must utilize statistically valid sampling methods for monitoring compliance with these standards (e.g., beneficiary and provider surveys).

b. Any exceptions to these standards must be justified to the State, and approved by the State. The State shall notify HCFA of any exceptions.

Attachment E

Phase-In Of Enrollment Under The Partnership Plan

OVERVIEW

Mandatory enrollment under The Partnership Plan will be accomplished in accordance with a HCFA-approved phase-in plan based on geography and Medicaid eligibility group, submitted by the State. The State must phase in 47 counties, and 5 boroughs of New York City. HCFA will approve (certify) the general operational readiness of specific boroughs and counties in accordance with the phase-in plan delineated below. (Because FHPlus will be implemented statewide, and the only phase-in is related to income, there will only be a single certification process and readiness review related to FHPlus). HCFA's certification process will include a detailed review of plan networks, both to certify the provider capacity required to serve beneficiaries in a particular area, as well as to ensure that MCOs have the capacity to serve the special needs populations that are targeted for enrollment. All of the conditions imposed in this attachment will be applicable to all phases of the phase-in plan.

I. General Conditions

1. No FFP will be provided for any marketing, enrollment or implementation of any aspect of this demonstration, or any phase of the phase-in plan, until HCFA formally notifies the State that the requirements, as specified below, and those throughout this document that are prefaced with an asterisk (*), are met.

2. HCFA will provide a checklist of areas that will be covered in the State- and LDSS-level reviews prior to the start of Partnership Plan operations. Prior to the start of each phase of the five-phase implementation plan, a team of HCFA personnel will use the checklist to certify the readiness of State and LDSS operations relevant to The Partnership Plan program. HCFA reserves the right to request additional documentation from either the State or LDSS or to follow additional lines of questioning within the broad areas specified in the checklist.

3. Prior to HCFA allowing the State to expand implementation under subsequent phases of the phase-in plan, the State must demonstrate, to HCFA's satisfaction, that the enrollment and disenrollment processes are working effectively in the previously implemented phase(s).

4. As part of the operational protocol, it is understood that the State shall describe specific procedures for disenrolling eligible individuals from MCOs that were not selected as contractors under The Partnership Plan program, and enrolling them in MCOs that have been qualified and selected to serve beneficiaries under the program.

II. Phase-in Plan/Required Documentation for Certification of Each Phase

1. The geographic component of The Partnership Plan phase-in shall be accomplished in five phases. The eligibility groups initially targeted for mandatory enrollment in each of the five

phases will consist of the AFDC and related populations and Home Relief recipients. All other Medicaid eligibility groups indentified in Attachment B will be enrolled according to the specifications outlined in Section III of this attachment.

2. The State shall provide the following information to enable HCFA to assess the operational readiness of each county/borough that the State has designated in each phase of the phase-in plan:

   a. Documentation regarding the enrollment process in each designated borough and county of a particular phase, including: 1) Whether the borough/county will utilize an independent enrollment broker or in-house staff; 2) the number and distribution of enrollment workers; 3) the language capabilities of the enrollment workers; 4) a description of the educational process that will be used to educate the beneficiaries and providers, in particular, how disabled and homeless beneficiaries who are unable to get to the enrollment offices are to be informed of their options; 5) how the enrollment offices will serve the vision and hearing impaired; and 6) the availability of one-on-one counseling for individuals who request or require it. HCFA reserves the right to perform on-site reviews of the enrollment process in any or all participating areas of The Partnership Plan.

   b. A comprehensive description of the contents of the beneficiary education curriculum.

   c. Copies of all training materials, scripts, hand-outs, etc. that the education vendor or LDSS staff will incorporate into the education curriculum.

   d. Documentation that a system is in place for monitoring the effectiveness of the independent enrollment broker or, if applicable, LDSS staff. The system must have the ability to alert the State to high rates of default assignments, and monitor the availability of translation services and materials.

   e. A listing of all MCOs that have been qualified and selected by LDSSs, and their complete provider networks, including all the information required in Section III.C.2.c. and III.D.2.b. of these terms and conditions, along with documentation that the State has certified those MCOs to begin enrolling beneficiaries in each county/borough.

   f. The estimated number of beneficiaries to be enrolled, by borough/county. The estimates must include the number of individuals, by eligibility category, who may enroll in mainstream plans on a voluntary basis.

   g. A description of the process for identifying and enrolling special needs populations, e.g., individuals with HIV disease, SPMI adults and SED children, developmentally disabled individuals, homeless families and adults, individuals with chemical dependencies, foster children, and others who may enroll on a voluntary basis, such as Native American populations. A description of how populations with special needs will be informed of their rights and options under The Partnership Plan must be included.

h. The availability of hot line services that beneficiaries who reside in the borough/counties designated for initiation of enrollment may access (including specific languages that the hot lines can accommodate).

i. Documentation that a) the MCOs which beneficiaries may choose have formal grievances and complaints processes for Partnership Plan enrollees, in accordance with Federal regulations at 42 CFR 434, Subpart C; and b) Partnership Plan enrollees have been informed of their complaint, grievance and appeal rights, and how to exercise them. In addition, documentation that the appeals process at the State level meets the requirements of 42 CFR 431, Subpart E, must be provided.

j. Any borough- or county-specific information that departs from the policies and procedures described in the approved operational protocol.

k. Any other information that HCFA deems necessary in order to approve the readiness of a given borough or county.

3. The State shall make available to HCFA any results of computer mapping programs run by the State to assess provider capacity or geographic accessibility under The Partnership Plan. In addition, the State shall make available the addresses of Partnership Plan providers and eligible participants to enable HCFA to run a computer mapping program as part of its efforts to assess provider capacity.

4. Mandatory enrollment under phase II will begin no sooner than 4 months after the initiation of mandatory enrollment under phase I (provided that HCFA has certified the operational readiness of the designated counties in each phase). Mandatory enrollment under phase III will begin no sooner than 4 months after the initiation of mandatory enrollment under phase II. If mandatory enrollment proceeds without significant problems, either administratively or operationally, mandatory enrollment in phase IV may be initiated 3 months after the initiation of mandatory enrollment under phase III, and mandatory enrollment in phase V may be initiated 3 months after the initiation of mandatory enrollment under phase IV (provided that HCFA has certified the operational readiness of the designated counties in each phase).

5. HCFA will render a decision (i.e., will either certify, or provide specific reasons for failure to certify) on the operational readiness of each stage of the phase-in plan within 60 days of the State's submission of the required documentation, as delineated above. If HCFA determines that certain counties in a given phase are not operationally ready, HCFA may allow the State to proceed with mandatory enrollment in those counties which have demonstrated operational readiness and withhold certification of the others until the State documents their operational readiness. The State may submit the documentation required to obtain HCFA certification of subsequent stages of the phase-in plan at any time following the certification and initiation of enrollment in previous areas. However, all required documentation must be submitted at least 60 days prior to the expected implementation date, as set forth in the phase-in plan, if the State intends to initiate mandatory enrollment in accordance with the approved phase-in schedule. In addition, the State's enrollment and disenrollment processes and information management systems must be working effectively in previously implemented phases before HCFA will approve the initiation of enrollment in subsequent phases of the phase-in plan. As part of this

provision, the State will be required to document the default assignment rates in previously implemented areas.

6. HCFA reserves the right to request documentation from the State in order to assess provider capacity at any time during or subsequent to the implementation of a given phase.

7. HCFA reserves the right to halt enrollment in any area where there are serious and uncorrected problems in the enrollment/disenrollment processes or the management information systems necessary to administer the program, or in beneficiary access to or quality of care. The State will, however, be given a reasonable period of time to substantiate complaints before such action is taken by HCFA.

8. Prior to enrollment of the SSI population on a mandatory basis, HCFA reserves the right to initiate a separate review to certify that participating MCOs have the capacity to serve the SSI population.

9. A similar review and certification process will be undertaken by HCFA prior to the enrollment of individuals with HIV disease, SPMI adults, SED children (and individuals who exhaust the basic mental health package offered by the mainstream MCOs) into SNPs, once they are established through the milestone process described in Attachment H.

III. Enrollment of Special Populations

1. The State may not mandatorily enroll individuals for whom SNPs are being developed (i.e., individuals with HIV disease (defined as individuals who are HIV-positive, but asymptomatic, individuals with symptomatic HIV disease and individuals with symptomatic AIDS), SPMI adults, and SED children) in managed care arrangements until SNPs are established and certified to accept eligible Partnership Plan enrollees through the milestone process. Mandatory enrollment of all other eligible populations, with the exception of the AFDC, AFDC-related, and Home Relief recipients, may not begin prior to the second operational year, defined as one calendar year from the implementation of the first phase of the phase-in plan (and only in areas that HCFA has certified to begin operations). This includes SSI individuals who are not eligible for SNPs. This does not, however, preclude individuals who may enroll in mainstream MCOs on a voluntary basis from doing so, prior to the second operational year, in all applicable areas of the State.

2. HIV-positive individuals shall be enrolled initially into mainstream MCOs and State-qualified SNPs, where available, on a voluntary basis (see Attachment F). The enrollment of individuals with HIV disease (including individuals who are HIV-positive, but asymptomatic, individuals with symptomatic HIV disease and individuals with symptomatic AIDS) in managed care arrangements will not be mandatory until SNPs are established and certified to accept Partnership Plan enrollees through the milestone process. In areas where SNPs are not available, enrollment of individuals with HIV disease into mainstream plans will remain voluntary. As part of the protocol, the State shall provide a description of the process for identifying and enrolling individuals with HIV disease, in each borough or county that has been designated for enrollment under The Partnership Plan. Provisions for maintaining the confidentiality of information on HIV-positive enrollees must also be included in this

description. (For additional information on the enrollment of individuals with HIV disease, see Attachment F.)

3. SPMI adults and SED children shall be enrolled initially into mainstream MCOs and State-qualified SNPs, where available, on a voluntary basis (see Attachment G). Enrollment of these individuals in managed care arrangements will not be mandatory until SNPs are established and certified to accept Partnership Plan enrollees through the milestone process. In areas where SNPs are not available, enrollment of these individuals into mainstream plans will remain voluntary. As part of the protocol, the State shall provide a description of the process for identifying and enrolling SPMI and SED individuals, in each borough or county that has been designated for initiation of enrollment under The Partnership Plan. Provisions for maintaining the confidentiality of information on these populations must be included in this description. (For additional information on the enrollment of SPMI adults and SED children, see Attachment G.)

Attachment F

Enrollment Of HIV-Positive Individuals In The New York State Partnership Plan

The following provisions, and concomitant terms and conditions, will apply to the enrollment of individuals with HIV disease (defined as individuals who are HIV-positive, but asymptomatic, individuals with symptomatic HIV disease, and individuals with symptomatic AIDS) into the Partnership Plan demonstration program. Enrollment of this population is expected to occur in two phases. During the first phase, when HIV SNPs are expected to be available, but not yet certified by HCFA as part of the milestone process (see Attachment H), individuals with HIV disease may enroll in these SNPs on a voluntary basis. During the second phase, when SNPs are established in accordance with the milestone process, individuals with HIV disease will be required to enroll in a managed care delivery arrangement (with the option to enroll in a HIV SNP). With respect to FHPlus, enrollment in HIV SNPs is precluded until such time as one or more HIV SNPs applies and is approved by the state and HCFA to offer the FHPlus benefit package. The enrollment options for individuals with HIV disease are described in detail below.

I. Provisions For Enrolling Individuals With HIV Disease

a. Voluntary Enrollment in HIV SNPs Prior to Completion of the Milestone Process (i.e., New York State=s Voluntary Mental Health SNP Program)

Before the milestone process is completed, individuals with HIV disease may voluntarily enroll in either (a) State-qualified mainstream MCOs, which will provide the same benefits available to other Partnership Plan enrollees residing in the same service area or; (b) State-qualified HIV SNPs in the service area in which they reside (if available). Individuals with HIV disease who elect not to voluntarily enroll in State-qualified mainstream MCOs or HIV SNPs, if available, will continue to receive Medicaid benefits in the fee-for-service (FFS) delivery system.

b. Partnership Plan SNPs Established through the Milestone Process

Once SNPs are established and certified through the milestone process (see Attachment H, which outlines the requirements for converting voluntary, State-qualified SNPs to Partnership Plan SNPs), individuals with HIV disease must enroll in a managed care arrangement (either mainstream MCOs or SNPs). Individuals who reside in service areas where SNPs are available will no longer have the option of remaining in the FFS delivery system. As soon as HIV SNPs are established through the milestone process in a given service area, those HIV-positive individuals in that area who have voluntarily enrolled in mainstream MCOs will be given the option of enrolling in a SNP. As part of the required protocol, the State must describe the process for informing individuals who are voluntarily enrolled in mainstream MCOs of the opportunity to enroll in HIV SNPs, once the milestone process has been completed.

c. Enrollment in Areas with no HIV SNPs

The State anticipates that there will be some areas where SNPs may not be viable; hence it is likely that certain service areas will not have HIV SNPs as an alternative to mainstream plan enrollment. If HIV SNPs are not eventually established in certain areas of the State, individuals with HIV disease may: a) remain in the FFS delivery system; or b) voluntarily enroll in mainstream MCOs in the service area in which they reside.

II. Terms And Conditions Pertaining To The Enrollment Of Individuals With HIV Disease

The following terms and conditions apply to the enrollment of individuals with HIV disease in boroughs and counties that have been certified to initiate mandatory MCO enrollment under The Partnership Plan. Unless otherwise indicated, the following terms and conditions apply to scenarios I.a.-I.c. of this attachment.

A. Certification Criteria

1. In order to ensure that all eligible HIV-positive individuals, asymptomatic or symptomatic, receive appropriate treatment services and have access to the expertise needed to treat them throughout the course of the disease, the State shall submit the following information for mainstream MCOs in areas designated for phase in:

    a. The criteria that the State is using to substantiate the readiness of mainstream MCOs to serve eligible individuals with HIV disease.

    b. A listing, by MCO, of all Department of Health (DOH) designated entities, including practitioners participating in DOH=s HIV Enhanced Fees for Physicians Program, with the clinical expertise and training necessary to serve individuals with HIV disease. The listing must include the corporate and common practice name of such providers, their telephone number(s), and address(es). It must also describe their ability to accommodate languages other than English.

    c. The name, telephone number, and address of other entities/providers within each MCO network that are critical to the care of individuals with HIV disease, including hospices, pharmacies, hospitals, and any other applicable institutional and non-institutional providers shall be listed by MCO.

B. Enrollment/Disenrollment

1. The operational protocol shall include a description of the education and enrollment processes that will be employed specifically for individuals with HIV disease.

2. Individuals with HIV disease, whether symptomatic or asymptomatic, who cannot obtain appropriate treatments within the mainstream MCO or SNP network, which could significantly increase the risk to the enrollee=s health, may avail themselves of the expedited complaint process which is to be described as part of the complaint and appeal section of New York=s operational protocol. (See section III.E.3.b. of these special terms and conditions for the requirements on the expedited complaint procedures.) Individuals who disenroll under such circumstances in areas without SNPs may either enroll in a different mainstream MCO, or may

receive care on a fee-for-service basis. Individuals who disenroll under such circumstances from a HIV SNP may either elect to enroll in a mainstream MCO available in the service area in which they reside or another SNP. If there is no other HIV SNP in which to enroll, they may elect to receive care on a fee-for-service basis. Individuals who disenroll under such circumstances from a mainstream MCO in areas where SNPs are available may either elect to enroll in a different mainstream MCO, or a SNP available in the service area in which they reside. The State shall include, as part of its required protocol, the process for informing beneficiaries of their right to expedited disenrollment under these circumstances.

3. Individuals with HIV disease who reside in areas where SNPs are available (scenario I.b. of this attachment) may select a SNP or a MCO in accordance with the provisions outlined in III.C.2.f. above. If such individuals fail to select either a SNP or a MCO in which to enroll within the prescribed time period, they may be assigned to a SNP in the service area in which they reside.

4. Individuals who are identified as HIV-positive subsequent to enrollment in a mainstream MCOs must be notified of their options: (a) to remain in the mainstream MCO or disenroll and return to the FFS system in areas without HIV SNPs; (b) to enroll in a HIV SNP in service areas where HIV SNPs are available; or (c) disenroll and subsequently enroll in a different mainstream MCO. In addition, individuals with HIV disease have the same right to change MCOs as do other Partnership Plan enrollees (this includes the 30 or 60-day grace period for changing MCOs, open enrollment periods, just cause disenrollments, etc.). The protocol must specify, by borough/county, the process (e.g., who will be responsible for the notification, the time frame for notification, etc.) for informing such individuals of their options.

C. Access to Services

1. All enrolled individuals with HIV disease may request standing referrals to MCO-participating specialists with expertise in treating HIV disease or may request a specialist as their PCP, consistent with provisions outlined in section III.C.2.k.(c) of these terms and conditions.

2. All enrolled individuals with HIV disease shall have access to appropriate treatments and all FDA-approved drugs and treatments for HIV disease (e.g., the newly-approved protease inhibitors and requisite viral load testing). Individuals with HIV disease who cannot obtain appropriate treatments and drugs, which would significantly increase the risk to the enrollee=s health, may avail themselves of the expedited complaint process to be described as part of the complaint and appeal section of New York=s operational protocol. (See section III.E.3.b. of these special terms and conditions for the requirements on the expedited complaint procedures.) The State shall have in place an HIV-specific mechanism for monitoring the adequacy of the MCO or SNP=s formulary and timely access to medically necessary services. The State may require the MCO or SNP to provide pharmaceutical services to an enrollee, as appropriate, until a resolution is made concerning an enrollee=s alleged problem accessing treatment.

D. Quality Assurance

1. The New York State Department of Health, in conjunction with the AIDS Institute, shall define specific quality measures that are to be reported, at least annually, by mainstream MCOs and

SNPs. In addition, the DOH, during the course of The Partnership Plan program, shall conduct a focused clinical study, across MCOs and SNPs, to assess the quality of care provided to Partnership Plan participants with HIV disease and to ensure that treatment is provided according to current standards of care.

2. As part of the operational protocol, the State must include a plan for monitoring access to and quality of care for individuals with HIV disease who enroll in mainstream MCOs and HIV SNPs (both in the State=s voluntary SNP program, and The Partnership Plan demonstration). The plan shall define all relevant quality indicators to be studied, explain the methodology for monitoring such indicators, at least annually, and discuss a strategy for requiring corrective action, where appropriate.

Attachment G

Enrollment Of Seriously Mentally Ill Individuals And Individuals Who Require Extended Mental Health Services In The Partnership Plan

The following provisions, and concomitant terms and conditions, will apply to the enrollment of SNP-eligible individuals (unless otherwise indicated, defined as seriously and persistently mentally ill (SPMI) adults and seriously emotionally disturbed (SED) children, as well as individuals who require extended mental health services (i.e., Partnership Plan enrollees who exhaust the basic benefit package offered by the mainstream MCOs and enroll in mental health SNPs) into the Partnership Plan demonstration program. Enrollment of the SNP-eligible population is expected to occur in two phases. During the first phase, when mental health SNPs are expected to be available, but not yet certified by HCFA as part of the milestone process (see Attachment H), SNP-eligible individuals may enroll in these SNPs on a voluntary basis. During the second phase, when SNPs are established in accordance with the milestone process, SNP-eligible individuals will be required to enroll in a managed care delivery arrangement (with the option to enroll in a mental health SNP). State authorization for the mental health SNPs expired in 2000. Consequently, mental health SNPs will not be implemented until such time as state authorization is in place. Should mental health SNPs be reauthorized, enrollment in such SNPs is precluded for FHPlus eligibles until such time as one or more mental health SNP applies for and is approved by the state and HCFA to offer the FHPlus benefit package. The enrollment options for SNP-eligible individuals are described in detail below.

I. Provisions For Enrolling SNP-Eligible Individuals

a. Voluntary Enrollment in Mental Health SNPs Prior to Completion of the Milestone Process (i.e., New York State's Voluntary Mental Health SNP Program)

Before the milestone process is completed (see Attachment H), SNP-eligible individuals may **voluntarily** enroll in either: (a) State-qualified mainstream MCOs, which will provide the same physical and mental health benefits available to other Partnership Plan enrollees residing in the same service area; (b) State-qualified mainstream MCOs for physical health-only benefits, and continue to receive mental health benefits on a fee-for-service (FFS) basis; or (c) co-enroll in a State-qualified mainstream MCO in the service area in which they reside for the delivery of physical health-only benefits, and a State-qualified mental health SNP in the same service area, if available, for their mental health services. SPMI adults and SED children who do not elect to voluntarily enroll in a mainstream MCO shall continue to receive both physical and mental health benefits on a FFS basis.

b. Partnership Plan SNPs Established through the Milestone Process

Once SNPs are established and certified through the milestone process (see Attachment H**,** which outlines the requirements for converting voluntary, State-qualified SNPs to Partnership Plan SNPs), enrollment in SNPs will remain voluntary for the SNP-eligible population, with the exception of SPMI adults and SED children who have not selected a mental health option and are auto-assigned to a mental health SNP, and any Partnership Plan enrollee who exhausts the basic mental health benefit package offered by the mainstream MCOs in which they are enrolled. These individuals will be mandatorily enrolled in a certified SNP for receipt of mental health services. However, a FFS option

for mental health services will only be offered in counties where there is only one mental health SNP which is operated by the county. As part of the required protocol, the State must describe the process for informing individuals who are voluntarily enrolled in mainstream MCOs of the opportunity to enroll in SNPs, once the milestone process has been completed.

c. Enrollment in Areas with no SNPs for Mental Health Benefits

The State anticipates that there will be some areas where SNPs may not be viable; hence it is likely that certain service areas will not have SNPs for the provision of mental health benefits. If SNPs are not eventually established in certain areas of the State, individuals who would otherwise be eligible for enrollment in mental health SNPs may: (a) receive both mental health and physical benefits on a FFS basis; (b) voluntarily enroll in certified mainstream MCOs and receive the same physical and mental health services available to other Partnership Plan enrollees residing in the same service area; or (c) voluntarily enroll in certified mainstream MCOs for the provision of physical health-only services and receive mental health benefits on a FFS basis.

II. Terms And Conditions Pertaining To The Enrollment Of SNP-Eligible Individuals

The following terms and conditions apply to the enrollment of SNP-eligible individuals in boroughs and counties **that have been certified to initiate mandatory MCO enrollment under The Partnership Plan.** Unless otherwise indicated, the following terms and conditions apply to scenarios I.a.-I.c. of this attachment.

A. Certification Criteria

1. In order to ensure that all SNP-eligible individuals receive appropriate treatment services and have access to the expertise needed to treat them throughout the course of the disease, the State shall submit the following information for mainstream MCOs in areas designated for phase in:

    a. The criteria that the State is using to substantiate the readiness of mainstream MCOs to serve SNP-eligible individuals.

    b. A description of how the physical health-only care provided through the mainstream MCO will be coordinated with the mental health care received on a FFS basis for SNP-eligible individuals who are voluntarily enrolled in a mainstream MCO and elect this service delivery option.

    c. A listing, by MCO, of all behavioral health providers, by type, and specialists necessary to serve SNP-eligible individuals. The listing must include the corporate and common practice name of such providers, their telephone number(s), and address(es). It must also describe their ability to accommodate languages other than English.

    d. The name, telephone number, and address of other entities/providers within each MCO network that are critical to the care of SNP-eligible individuals, including pharmacies, hospitals, and other designated institutional and non-institutional providers shall be listed by MCO.

B. Enrollment/Disenrollment

1. The operational protocol shall include a description of the education and enrollment process that will be employed specifically for SNP-eligible individuals and, if appropriate, for their designated representatives.

2. SPMI adults and SED children who cannot obtain appropriate treatment within the MCO (or SNP) network, which could significantly increase the risk to the enrollee's health, may avail themselves of the expedited complaint process which is to be described as part of the complaint and appeal section of New York's operational protocol. (See section III.E.3.b. of these special terms and conditions for the requirements on the expedited complaint procedures.) Individuals who may disenroll under such circumstances in areas without mental health SNPs have the same options as outlined in I.c. of this attachment. Individuals who disenroll from a mental health SNP have the same options as outlined in 1.a.of this attachment (if enrolled in a State-qualified SNP) or 1.b. (if enrolled in a Partnership Plan SNP established through the milestone

process). However, if there is no other mental health SNP in which to enroll, they may elect to receive care on a FFS basis. The State shall include, as part of its required protocol, a description of the process for informing beneficiaries of their right to expedited disenrollment under these circumstances.

3. Individuals who are identified as eligible for enrollment in SNPs subsequent to enrollment in a mainstream MCO must be notified of their options. In areas where no certified SNPs are available, they may: (a) remain in the MCO in which they are currently enrolled for the provision of physical health-only benefits and receive mental health benefits on a fee-for-service basis; (b) receive the comprehensive benefit package available to any other Partnership Plan enrollee in the mainstream MCO in which they are currently enrolled, or a different MCO; or (c) disenroll and return to the FFS system. In areas where certified SNPs are available, SPMI adults and SED children may: (a) enroll in a SNP for their mental health benefits, and remain in their current MCO, or disenroll and enroll in a different MCO for the provision of physical health-only benefits; or (b) receive the comprehensive benefit package available to any other Partnership Plan enrollee either through the MCO in which they are currently enrolled, or a different mainstream MCO. Once any Partnership Plan enrollee exhausts the basic mental health benefit available in the mainstream MCO, he or she would be mandatorily enrolled in a mental health SNP for the receipt of further mental health services.

4. The State will develop a mechanism for periodically evaluating individuals who are enrolled in mental health SNPs to determine their continued eligibility for SNP services as part of the milestone process outlined in Attachment H. If there are no certified SNPs available in the area in which they reside, Partnership Plan participants who exhaust the basic mental health benefit available in the mainstream MCO in which they are enrolled may then receive mental health services on a FFS basis. Individuals who are eligible for enrollment in a mental health SNP have the same right to change MCOs as do other enrollees (this includes the 30 or 60-day grace period for changing MCOs, open enrollment periods, just cause disenrollments, etc.). The protocol must specify, by borough/county, the process (e.g., who will be responsible for the notification, the time frame for notification, etc.) for informing such individuals of their options.

C. Access to Services

1. If it is in the best interest of a SNP-eligible enrollee who is voluntarily enrolled in a mainstream MCO, that person may select a PCP and receive standing referrals to their primary mental health practitioner who is part of the MCO=s provider network. The primary mental health practitioner will work in conjunction with the PCP.

2. All enrolled SNP-eligible individuals shall have access to appropriate therapies and all Food and Drug Administration (FDA)-approved drugs (either brand name or generic) and combinations of drugs for their conditions/diseases. Individuals who experience problems accessing treatment, without which could significantly increase the risk to the enrollee=s health, may avail themselves of the expedited complaint process which is to be described as part of the complaint and appeal section of New York=s operational protocol. (See section III.E.3.b. of these special terms and conditions for the requirements on the expedited complaint procedures.) The State shall have in place a behavioral health-specific mechanism

for monitoring the adequacy of the SNP=s formulary and timely access to medically necessary services. The State may require a SNP to provide pharmaceutical services, as appropriate, to an enrollee until a resolution is made concerning an enrollee=s alleged problem accessing treatment.

D. Quality Assurance

1. The New York State Department of Health (DOH), in conjunction with the Office of Mental Health (OMH), shall define specific quality measures that are to be reported, at least annually, by mainstream MCOs. In addition, during the course of The Partnership Plan program, the DOH, in conjunction with OMH, shall conduct a focused clinical study, across MCOs, to assess the quality of care provided to Partnership Plan participants eligible for enrollment in mental health SNPs and to ensure that treatment is provided according to current standards of care.

2. As part of the operational protocol, the State must include a plan for monitoring access to and quality of mental health services provided by mainstream MCOs and SNPs (both in the State=s voluntary SNP program, and The Partnership Plan demonstration). The plan shall define all relevant quality indicators to be studied, explain the methodology for monitoring such indicators, at least annually, and discuss a strategy for requiring corrective action, where appropriate.

Attachment H

Milestone Approach To The Developmentof Special Needs Plans (SNPs)

The Partnership Plan proposal includes the establishment of special needs plans (SNPs) for individuals with HIV/AIDS, and the seriously mentally ill (defined as seriously and persistently mentally ill (SPMI) adults, and seriously emotionally disturbed (SED) children) and individuals who require extended mental health services. The State will develop these SNPs, with HCFA oversight, under a milestone approach that is mutually agreeable to the State and HCFA. The milestone approach that is outlined in this attachment includes a detailed implementation plan, with specific tasks leading to the development of SNPs, and the required sequence for the completion of these tasks.

Prior to the successful completion of these tasks, and upon approval of the SNP networks, State-qualified SNPs may be made available for eligible individuals to voluntarily enroll in. It is understood that the terms and conditions, as prescribed throughout this document, shall apply to individuals enrolled in SNPs available through the State=s voluntary program or Partnership Plan SNPs established through the milestone process set forth in this attachment. However, HCFA reserves the right to modify these SNP terms and conditions, or impose new terms and conditions upon completion of these milestone tasks.

The State is encouraged to involve the relevant subcommittees for the Partnership Plan, and other interested parties, as each milestone task is developed and implemented. The tasks depicted in the chart below, and differentiated by type of SNP, are milestones which must be completed and approved by HCFA before SNPs can be certified to begin operations under The Partnership Plan.

Provisions For Enrollment In SNPS On A Voluntary/ Basis Prior To Completion

Of The Milestone Process

The State shall follow the milestones specified in Attachment H of this document in developing and implementing the Special Needs Plans (SNPs) for persons with HIV-positive infection or AIDS. HCFA will monitor this development process and will be responsible for authorizing Federal financial participation for the payments made to the HIV SNPs prior to any enrollment, whether in the State=s voluntary program or Partnership Plan SNPs established through the milestone process. Authorization to begin enrollment in the State=s voluntary SNP program will be given upon HCFA=s approval of SNP contracts. No Federal financial participation will be available for payments to HIV SNPs unless HCFA has approved the contract, the capitation rates, and the rate-setting methodology. The contract will specify in detail the requirements of program contractors in all pertinent areas including, but not limited to: access standards, referral process, quality management, enrollment and disenrollment, and grievance and appeals. All contractors must successfully complete a State readiness review. Conversion of the State=s voluntary SNP program to The Partnership Plan program is contingent upon HCFA=s approval of a report, submitted by the State, that provides an analysis of quality of care and client satisfaction in the State=s voluntary SNPs and demonstrates that all milestone tasks not specifically addressed as part of the contract approval process have been met. In addition, enrollment in HIV SNPS may only begin after HCFA has authorized such enrollment through the extension of the freedom of choice waivers requested as part of this Demonstration to this population.

Mental health SNPs developed for adults with serious and persistent mental illness (SPMI) and seriously emotionally disturbed (SED) children and individuals who require extended mental health services will not be developed as fully capitated programs. Authorization to begin enrollment in the State=s voluntary SNP program will be given upon HCFA=s review of SNP contracts. Conversion of the State=s voluntary SNP program to The Partnership Plan program is contingent upon HCFA=s approval of a report, submitted by the State, that provides an analysis of quality of care and client satisfaction in the State=s voluntary SNPs and demonstrates that all milestone tasks not specifically addressed as part of the contract approval process have been met. In addition, enrollment in the Behavioral Health SNPs may only begin after HCFA has authorized such enrollment through the extension of the freedom of choice waivers requested as a part of this Demonstration to this population for these services.

Unless enrolled in a mental health SNP in the State=s voluntary SNP program, all SPMI adults and SED children will be permitted to obtain Medicaid covered mental health services through the fee-for-service Medicaid program until SNPs are established through the milestone process. The State anticipates that the milestone process will be completed in calendar year 1998.

MILESTONE TASKS FOR ESTABLISHING SPECIAL NEEDS PLANS (SNPs)		
	HIV/AIDS	**SPMI Adults/ SED Children**
Operational Protocol Development	**X**	**X**
RFP Development		
- Develop RFP for procurement of SNPs.	**X**	**X**
- Establish SNP certification criteria and criteria for evaluating SNP bids.	**X**	**X**
Benefit Package		
- Establish the in-plan SNP benefit package.	**X**	**X**
Ratesetting		
- Develop ratesetting methodology for SNPs.	X	X
- Finalize and submit proposed capitation rates to HCFA.	X	X
- Develop a stop-loss "re-insurance" program for SNPs, including the methodology for determining the stop-loss level.	X	X
Computer Systems		
- Develop and implement SNP-related systems modifications, which include the capacity to differentiate SNP enrollees from mainstream plan enrollees, to pay distinct SNP capitation payments, to register SNP enrollments and transfers on a timely basis, etc. Procedures for preserving the confidentiality of enrollees must also be developed.	X	X
AX≅ denotes that the task applies to the development of the particular SNP. Once the milestone plan is finalized, the AXs≅ will be replaced with specific dates for completion of the tasks.		
MILESTONE TASKS FOR ESTABLISHING SPECIAL NEEDS PLANS (SNPs)		
	HIV/AIDS	**SPMI Adults/ SED Children**

Education and Outreach		
- Develop education and outreach materials for individuals eligible for enrollment in SNPs.	X	X
Enrollment/Disenrollment		
- Develop criteria and screening and assessment tools to identify individuals in the SNP populations, and a process for ensuring that these individuals receive information regarding their options for voluntary enrollment prior to SNP availability.	X	X
- Develop operational procedures for enrollment into, and disenrollment from SNPs. These include procedures for initially enrolling eligible FFS individuals into approved SNPs, as well as transferring eligible individuals into SNPs who are voluntarily enrolled in mainstream MCOs. The process for disenrollment must include disenrollments for good cause.	X	X
Provider Capacity		
- Develop specific criteria and methodology for evaluating provider capacity within SNPs.	X	X
- Approve provider networks within individual SNPs to assure that the plans have adequate representation of specialty and sub-specialty providers, and adequate provider capacity to serve the number of SNP-eligible beneficiaries to be enrolled in a given service area.	X	X
- Establish a process for determining the location and number of SNPs.	X	X

AX≅ denotes that the task applies to the development of the particular SNP. Once the milestone plan is finalized, the AXs≅ will be replaced with specific dates for completion of the tasks.

MILESTONE TASKS FOR ESTABLISHING SPECIAL NEEDS PLANS (SNPs)

	HIV/AIDS	**SPMI Adults/ SED Children**

Access and Quality of Care		
- Develop a unique data set for populations enrolled in SNPs.	X	X
- Develop a written plan for monitoring quality of care and performance in the SNPs and assuring access to services (this includes the specification of quality indicators, and the methodology for measuring those indicators).	X	X
- Conduct a review of the established SNPs within 3 months of initial SNP enrollment to identify problem areas. (Ongoing reviews will then be conducted as described in the monitoring plan above.)	X	X
- Develop special complaint, grievance, and appeal procedures that are responsive to the needs of SNP enrollees (and the State=s approach for monitoring plan compliance with these procedures).	X	X
- Develop procedures and protocols for coordinating patient care in the mainstream plan and mental health SNP.		X

AX≅ denotes that the task applies to the development of the particular SNP. Once the milestone plan is finalized, the AXs≅ will be replaced with specific dates for completion of the tasks.

Attachment I

Persons And Services Subject To The Budget Neutrality Cap

The following describes which persons and service expenditures are to be subject to budget neutrality under the New York Partnership Plan 1115 Medicaid demonstration.

1. Eligibles counted on the with and without waiver side.

The term, APartnership Plan current eligibles,≅ refers to all persons who are or were eligible for Medicaid under the Medicaid State plan in effect during the base year period for budget neutrality, except for persons of the types listed below for the ADC and MA only ADC related populations. This list of exemptions may be revised for the SSI population once SSI recipients are included into the mandatory program, and will be subject to HCFA approval. Starting with the date FHPlus is implemented, the term "Partnership Plan Current Eligibles" shall also include FHPlus parents.

Exclusions:

Recipients with the following **characteristics** shall be excluded from the definition of APartnership plan current eligibles≅:

X Persons who obtained Medicaid eligibility through meeting a spend-down requirement[1]
X Medicare/Medicaid dual eligibles
X State Charge recipients (i.e., persons who have ACounty of fiscal responsibility≅ codes equal to 97, 98 or 99, as defined in the State=s current MMIS system)
X Foster Children in voluntary agencies

Recipients of the following **services** shall be excluded from the definition of APartnership plan current eligibles≅:

- Skilled nursing facility services[2]
- ICF/MR
- Home and Community Based waiver services (1915(c))
- State Operated Inpatient Psychiatric services (Office of Mental Health - Inpatient services)
- Waiver Services for Pregnant Substance Abusers
- Long Term Home Health Care Program services
- Residential Substance Abuse Program services
- Ambulatory Substance Abuse Program services

[1] These individuals shall be identified using a methodology consistent with the methodology used to identify spend-down eligibles for purposes of monitoring budget neutrality (see Section 4 below). A brief description of this procedure shall be included in the Operational Protocol.

[2] Partnership Plan current eligibles shall be counted as demonstration eligibles prior to their 45th consecutive days of SNF services.

- Residential Treatment Facility services
- OMR Inpatient

Each eligible member/month must be assigned to one of the following nine MEGs:

- AFDC, Age 21-64
- MA-AFDC, Age 21-64
- AFDC, and AFDC-related, Under 21
- MA-AFDC, and AFDC-related, Under 21
- SSI, 65 Years and Over
- MA-SSI, 65 Years and Over
- SSI, Under Age 65
- MA-SSI, Under Age 65
- FHPlus parents

Definitions of the MEGs will be included in the Operational Protocol, to be submitted by the State to HCFA under terms of Attachment C.

Additional definitions:

X The terms, APartnership Plan expansion eligibles,≅ and "Family Health Plus expansion eligibles" refer to persons who were not eligible under the base year period State plan, but who became eligible by virtue of the demonstration, except for persons enrolled in CHIP during the demonstration.

X The term, ACHIP eligibles,≅ refers to persons enrolled in the CHIP program during the demonstration period, who for purposes of budget neutrality are treated as if they had been Medicaid eligible under the base year Medicaid state plan, through an eligibility expansion under 1902(r)(2).

2. Service expenditures included in the base year

All service expenditures for persons who meet the definition of Partnership plan current eligibles in item 1 are to be included in the base year expenditure totals.

3. Eligible member/months to be reported during the demonstration

Eligible member/months for Partnership Plan current eligibles and CHIP eligibles (as defined above) should be reported during the demonstration, including both recipients enrolled in pre-paid plans and those who remain in fee-for-service Medicaid, regardless of the county or region of the State in which they reside, subject to the phase-in provisions of Attachment B.

4. Expenditures subject to the budget neutrality cap

The following medical assistance expenditures should be reported as expenditures subject to the cap:

- All medical assistance expenditures (including those for which reimbursement was made on a fee-for-service basis) for Partnership Plan current eligibles;

- All medical assistance expenditures for Partnership Plan expansion eligibles;

    - Federally matched expenditures for the programs listed in Attachment J, item 1. Federal matching funds for these programs combined may not exceed $250 million in FFP each DY. If FFP for CHIP alone equals or exceeds $250 million in any DY, then no FFP will be available for the other programs listed in Attachment J, item 1 in that year.

    - All DSH expenditures.

5. DSH expenditures counted under the budget neutrality cap

Because the period of the demonstration may not correspond to either a Federal or State fiscal year, the following will govern reporting of DSH expenditures subject to the budget neutrality cap:

- The **SFY DSH total** will be the sum of DSH expenditures made subject to the Omnibus Budget Reconciliation Act (OBRA) 93 hospital specific DSH limits for the State fiscal years which overlap the demonstration period, including fractions of years at the beginning and end of the demonstration as appropriate.

- The **FFY DSH total** will be the sum of DSH expenditures made subject to the annual DSH allotments for the Federal fiscal years which overlap the demonstration period, including fractions of years at the beginning and end of the demonstration as appropriate.

- The DSH expenditure subject to the budget neutrality cap shall be the greater of the SFY DSH total and the FFY DSH total.

Attachment J

Terms and Conditions Associated With The Community Health Care Conversion Demonstration Project

The State shall take necessary actions to implement the Community Health Care Conversion Demonstration Project (CHCCDP) to enable eligible hospitals to undertake health service delivery and work force restructuring activities.

1. The State will

   (a) claim Title XIX Federal matching for State payments made on or after the date of approval (July 15, 1997) through the:

   Professional Education Pool (PEP)
   Child Health Insurance Program (CHIP)
   New York Small Business Health Insurance Partnership Program
   New York Individual Voucher Program
   New York Individual Pilot Program
   Catastrophic Insurance Program
   Clinic, Laboratory and Ambulatory Surgery Indigent Care Distributions
   Elderly Pharmaceutical Insurance Coverage Program
   AIDS Drug Assistance Program

   (b) permit the Federal share of the matching payments to be allocated to hospitals participating in the CHCCDP.

   The State asserts it does not require amendments to State statutes to claim Title XIX Federal matching on the above programs. The HCFA agrees to make Title XIX Federal matching available for the above programs without change to existing State processes for making program payments.

   The HCFA agrees the distributions from the State=s pools for programs listed above in item 1(a) may be claimed in whole or in part. The HCFA further agrees that the claim for FFP may shift among facilities, increase or decrease upon a reconciliation of projected facility specific DSH ceilings to actual Medicaid and uninsured losses for a given period.

2. Funding for the CHCCDP will be from Federal Financial Participation made available to the State after it funds (with 100 percent State dollars) the programs identified in paragraph 1.a above.

   a. Federal matching funds for these programs combined shall not exceed $250 million per year (based on the date on which the State submits program costs to HCFA for match) and $1,250 million over the course of the demonstration, subject to the State=s ability to initiate a $500 million annual claim, within all applicable Federal payment limitations, for programs listed in Paragraph 1.a above. If Federal action or the application of

Federal laws or regulations adversely affect the State=s ability to generate the required $500 million claim for these programs, and there is mutual agreement that the claim cannot be achieved, acceptable alternative claims within all applicable Federal payments limitations must be mutually identified to maintain the annual level of funding pursuant to this paragraph. With these Federal funds, the State shall make payments to hospitals participating in the CHCCDP. Solely from the Federal funds available, total payments for the CHCCDP shall be equal to $250 million in each of five years of the demonstration.

b. An allowance for CHIP shall be included in the without waiver baseline, only to the extent that CHIP is eligible for Federal match as a cost not otherwise matchable and the Federal matching dollars are used for the purpose of funding CHCCDP (see also c, below). The State understands that, aside from CHIP, none of the sources of matching funds for CHCCDP may be included in the without waiver baseline.

c. To the extent that the State elects to use CHIP expenditures as the State match for Federal funds made available through Federal legislation (or for other Federal programs), these expenditures will not be eligible for Federal Medicaid match under the 1115 demonstration, and consequently will not be available to fund CHCCDP. In such instance and to the extent necessary, an acceptable alternative claim within all applicable Federal payment limitations must be mutually identified to maintain the annual level of funding authorized pursuant to this paragraph.

3. Federal matching funds for the programs identified in paragraph 1(a) above will be available to the State in any given year only if the State demonstrates it has legislative authority to spend these additional monies solely for awards under the CHCCDP.

4. The award of FFP for expenditures associated with the programs identified in 1(a) in no way results in these programs being an entitlement under the State=s Medicaid program or altering the benefit package under State law for these programs.

5. Payments under the CHCCDP will only be provided to hospitals that meet the criteria specified in 5a, and shall be limited to health service delivery and work force restructuring activities in conformity with the requirements outlined in item 9.

a. Eligibility for distribution of funds will be limited to public and voluntary hospitals in New York State that have at least 20 percent of total discharges from Medicaid and self-pay; have at least 5,000 total discharges per year; and certify that they will provide medically necessary care, available to privately-insured patients at that institution, to all indigent patients (including Medicaid patients who are not enrolled in a MCO, to the extent these services are covered under Title XIX) presenting themselves to the hospital for services.

For the first year of the demonstration, all eligible hospitals who meet the criteria defined above shall receive their funding allocation in accordance with the provisions in item 6. In subsequent years of the CHCCDP, funding allocations shall be limited to

hospitals that are participating in The Partnership Plan program, either as hospital-based MCOs, and/or subcontractors to Partnership Plan MCOs. Eligible hospitals that have not entered into contractual arrangements to serve partnership plan enrollees and wish to continue to receive CHCCDP funding, may appeal to the Commissioner of the New York State Department of Health. If the Commissioner determines that a hospital=s rationale for not having a contract is legitimate, an exemption to this requirement may be granted.

b. Funds will be allocated to hospitals according to the following formula: Each hospital will receive a percentage of the funds determined by the ratio of the hospital=s weighted Medicaid plus self-pay discharges to the total weighted Medicaid plus self-pay discharges of all participating hospitals. The weighting factor for each hospital will be the percentage of that hospital=s discharges that are Medicaid and self-pay.

c. In award year one the formulas in items 5a and 5b will be based on New York State Institutional Cost Report data for 1995. For subsequent award years, the formulas in items 5a and 5b will be based on New York State Institutional Cost Report data for the period two years preceding the award year.

d. HCFA and the State will work together to develop a mutually agreed upon allocation methodology based upon Medicaid and indigent outpatient visits that will modify the methodology described in b above. This methodology will be used for fund allocation for the second and subsequent years of the demonstration.

6. All upstate hospitals eligible for CHCCDP funding and participation in Phase 1 of mandatory enrollment under the Partnership Plan shall receive the full allocated amount in the first year, depending on the availability of funds, based on the formula prescribed in 5b above once HCFA has approved mandatory enrollment for Phase 1. At that time, all other eligible hospitals, including hospitals in New York City, shall receive 15 percent of their first year allocation, depending upon the availability of funds. Such eligible hospitals, depending on the availability of funds, shall receive an additional 15 percent once HCFA has approved a date certain agreeable to the Commissioner of Health for mandatory enrollment for Phase 2, with the balance to be disbursed once Phase II mandatory enrollment commences. Receipt of funding in any year is contingent on the eligible hospitals submitting an application to the State on an annual basis that details the restructuring goals of the upcoming year and accomplishments over the previous year, if applicable, including the activities outlined in item 9 below. Upon review of the applications, if the State determines that the hospitals have met their prior year restructuring goals and have appropriate goals for upcoming periods, hospitals will receive the full annual allocated amount, depending on available funds. Any funds not allocated to eligible hospitals, in whole or in part, as a result of failing to meet these requirements shall be reallocated to other eligible hospitals by the Commissioner pursuant to the formula described in 5b and 5c above. Funds distributed to eligible hospitals may be recouped by the Commissioner from such hospitals upon an audit finding that the expenditure of funds was not in keeping with the approved application for meeting CHCCDP goals.

7. All Title XIX payments made directly by the State to hospitals will be subject to the OBRA 1993 DSH limits. State CHCCDP awards to facilities are not Title XIX payments.

8. Within 60 days of approval of necessary State legislation, the State shall submit an amendment to the operational protocol for the Partnership Plan that describes in detail how the State will operate and monitor the CHCCDP, including (but not limited to) the following: the component of the State responsible for administering the CHCCDP; the model application form for hospitals; the allocation of funds to each hospital; the specific funding mechanism; the review and approval process to determine how hospitals will utilize the allocated funds; and the audit methodology to assure that funds are expended appropriately.

9. In order to expand primary care capacity in New York and to accommodate the restructuring in health facilities serving the poor, New York=s safety net infrastructure must be further strengthened. To accomplish this, in reviewing their applications, the State will encourage hospitals to incorporate the following types of linkages into their restructuring plans: enhanced linkages to existing article 28 diagnostic and treatment centers, pursuant to the State definition; establishment of new, hospital affiliated article 28 facilities (or subparts of facilities, including RHCFs and FQHCs); expansion or enhancement of existing affiliated article 44 preferred health services providers, or the creation of new, hospital affiliated article 44 providers; enhanced linkages with local health departments; establishment of new, hospital affiliated individual or physician primary care group practices in Federally-recognized medically underserved areas and health professional shortage areas.

10. If any Federal legislation or regulatory revisions affects aggregate Statewide disproportionate share limitations, upper payment limits, or aggregate or per-capita Medical Assistance payments limits, the State shall submit to HCFA a methodology for coming into compliance with the law. (See Section II.B. of these terms and conditions.)

    HCFA shall give deference in such methodology to State-proposed actions which give priority to preserving the eligibility status and benefits of recipients participating in the New York State Partnership Plan. Such methodology shall be in response to any Federal payment limitation resulting from this waiver or later Federal statutory or regulatory revisions, including but not limited to: facility specific disproportionate share distribution limits, aggregate statewide disproportionate share limitations, upper payment limits, and aggregate or per capita Medical Assistance payment limits. Funding levels for any program initiated under the terms and conditions of this waiver may be adjusted, in whole or in part, to fully accommodate the aforementioned Federal payment limitations and would be given favorable consideration for approval if the State can sufficiently demonstrate that access to needed services by State Medicaid recipients is not diminished.

11. The first phase of mandatory enrollment under The Partnership Plan will not be implemented until necessary State legislation has been enacted by the State Legislature to appropriate funds for the CHCCDP consistent with the aforementioned terms and conditions.

Attachment K

Encounter Data Set Elements

ELEMENTS	TYPE OF RECORD				
	PHYS & OTHER PROVS	HOSP	LTC	DRUGS	DENTAL
Beneficiary/Enrollee ID	X	X	X	X	X
Beneficiary/Enrollee Name	X	X	X	X	X
Beneficiary/Enrollee DOB	X	X	X	X	X
Plan ID	X	X	X	X	X
Physician/Supplier/Provider ID	X	X	X	X	X
Attending/Ordering/Referring Performing Physician ID	X	X	X	X	X
Provider Location Code/Adress	X	X	X	X	X
Place of Service Code	X	X	X	-	X
Specialty Code	X	-	X	-	-
Date(s) of Service	X	X	X	X	X
Units of Service/Quantity	X	X	X	X	X
Principal Diagnosis Code	X	X	-	-	-
Other Diagnosis Code(s)	X	X	-	-	-
Procedure Code	X	X	X	-	-
EPSDT Indicator	X	-	-	-	X
Patient Status Code	-	X	X	-	-
Revenue Code	-	X	X	-	-
National Drug Code	-	-	X	X	-
Dental Quandrant	-	-	-	-	X
Tooth Number	-	-	-	-	X

Attachment L

Guidelines For Quarterly Reporting On New York's Partnership Plan 1115 Demonstration

The quarterly report is used to inform HCFA and other interested parties of the quarter's activities and is distributed within HCFA and to others. After approval of FHPlus, each section should include discussion of issues pertaining specifically to FHPlus. The report should be a detailed rather than a general treatment of issues and events of the quarter. The document will typically be a narrative of between 25 and 50 pages. Ordinarily, there will be no attachments or appendices. The following outline may be used for the report.

1. Executive Summary

   Provide a brief overview of content of the report, giving just a few sentences about each topic. This section is usually no longer than 2 or 3 pages.

2. Significant Activities of the Quarter

   a) This section should highlight any significant activities or events that occurred during the quarter. Items would be included here even if they might ordinarily be covered elsewhere if the items in question were extraordinary or have attracted unusual attention. A description of press releases and issues covered by the press should be included, as should activities of advocacy groups.

   b) This section should also include problems or other issues that the State wishes to raise. It would include a discussion of problems that arose in the quarter or ongoing problems, solutions the State devised to deal with them or proposed State policies for dealing with them, new legislation affecting the demonstration, etc.

   c) This is also the place to provide information on any planned amendments to the protocol, program modifications (including benefit package changes or changes in the mix of carved-out vs. capitated services), or program expansions.

3. Eligibility/Enrollment

   a) Provide narrative and statistical information on enrollment and outreach activities, new enrollments, disenrollments, default assignments, and exemptions, broken out as appropriate by health plan, service area, eligibility group, etc.

   b) Include a discussion of the known or likely reasons for any changes in the above categories of data.

   c) Where available include data on the number of and reasons for different types of

disenrollments (voluntary, involuntary, for cause, health plan transfers), the numbers of denied for cause disenrollments, and the number of approved and disapproved exemptions.

d) Describe MEQC activities during the quarter.

e) Discuss any changes in eligibility criteria planned or implemented during the quarter.

f) Discuss beneficiary hotline performance and the performance of county and/or enrollment broker staff in the preceding quarter. Discuss any noteworthy problems or achievements in the Local Departments of Social Services (LDSSs) with regard to the implementation of mandatory enrollment.

4. Access/Delivery Network

a) Report on significant changes in provider networks in the preceding quarter and on any problems identified regarding beneficiary access to care.

b) Discuss any corrective actions taken by the State, LDSSs, and/or MCOs in response to problems, together with activities undertaken during the quarter aimed at assuring access to care.

5. Quality Assurance

a) Report on internal and external quality assurance activities during the quarter. Describe activities such as results of medical record reviews, focused studies, training of health plan staff, other activities of the State's quality improvement staff, etc.

b) Include plans for the next quarter's activities by both the State quality improvement staff and the External Quality Review Organization.

c) Provide a summary of the State's monitoring of MCO quality improvement activities.

d) Include results of any satisfaction survey that was conducted in the quarter.

e) Discuss efforts related to EPSDT, pregnant women, maternal and infant health:

f) Provide data on State monitoring activities for these groups, including training, auditing, and coordination with other agencies such as the Public Health Service. This area should include reporting by health plans on immunizations and other maternal and child services and any corrective actions planned or taken by the State.

g) Provide data on levels of compliance with EPSDT regulations.

h) Discuss QA monitoring activities relating to Special Needs Plans (SNPs) and clients with severe mental illness, HIV infection and AIDS who are being served by SNPs and mainstream MCOs under the demonstration. Discuss QA monitoring activities relating to clients with

disabilities, chronic illnesses and other special needs under the demonstration.

6. Complaints/Grievances

   a) Provide summary data on complaints, appeals, and Fair Hearings by category of problem, where the complaint/appeal/Fair Hearing was filed, resolution time, nature of corrective action taken, and the number of complaints/appeals/Fair Hearings that resulted in just cause disenrollments by MCO. When applicable, the above summaries should include information on complaints, appeals, and Fair Hearings for SNP enrollees.

   b) Include a discussion of the State's analysis of complaints and grievances and any actions taken or planned to address problem areas.

   c) Provide a summary of health plan complaint logs.

7. Budget Neutrality, Fiscal, and CHCCDP Issues

   a) Provide a discussion of financial issues, including changes in appropriations or changes in the benefit package that a new budget may require, etc.

   b) Include a discussion of anticipated fiscal problems or issues.

   c) Give the status of expenditures and obligations as they relate to the budget neutrality cap.

   d) Provide ongoing updates on the status of the Community Health Care Conversion Demonstration Project (CHCCDP). These should include information on: (a) how much of each demonstration year's payouts to safety net hospitals have been issued as of the date of the quarterly report; (b) what programs have been used as sources for what amounts of Federal match; (c) what hospitals have been approved for CHCCDP funding in the coming year; (d) what hospitals have been denied funding and why; and (e) a summary of the types of restructuring activities facilities receiving CHCCDP funds have undertaken.

8. Utilization

   a) When available, provide utilization tables by health plan, by eligibility group, by geographic area for the current quarter.

   b) Discuss the State's use of encounter data or other sources of health care data to monitor utilization of services and access to care.

   c) Discuss trends in utilization, and any unusual patterns about which the State will take follow-up action.

9. Systems

Describe any ongoing systems problems or systems problems that surfaced in the preceding quarter and their ramifications. Discuss the status of systems development initiatives. Include information on planned modifications and expected outcomes.

a) Discuss the status of encounter data (and other health data) reporting, collection, and processing, including punitive and corrective actions taken by the State.

10. Other

a) Discuss any issues not covered above that arose during the quarter that pertain to special populations, such as the severely mentally ill, the disabled, or others.

b) Discuss administrative changes or issues for both the State and MCOs.

c) Discuss contract issues and activities related to MCOs or outside firms.

d) Detail planned changes in operations at the State and/or LDSSs.

e) Provide information on MCO changes that have occurred in the past quarter, or potential upcoming changes, including ownership or solvency issues.

f) Discuss activities by other State departments that may have an impact on the demonstration.

g) Discuss other operational or administrative issues, such as hotline or training activities.

h) Discuss State, LDSS, and MCO efforts to monitor the program. Provide information on other relevant results of the quarter's activities, as well as plans for the next quarter.

i) Optionally, you may include a section to illustrate "best practices", including innovative solutions to problems, that you believe may be of help to other States.

Attachment M

Family Health Plus Benefits

The benefit package for FHPlus enrollees is defined as follows:

Physician services
Inpatient and outpatient health care
Prescription drugs
Smoking cessation products
Lab test and x-rays
Short term rehabilitation services (as defined by the Commissioner)
Vision care
Speech and hearing services
Durable medical equipment
Home health services (short term, acute care in lieu of hospitalization, up to 40 visits per year)
Family planning services and supplies
EPSDT services
Emergency room services
Emergency ambulance transportation
Inpatient mental health and alcohol and substance abuse services (up to 30 visits per year combined)
Outpatient mental health and alcohol and substance abuse services (up to 60 visits per year combined)
Diabetic supplies and equipment
Radiation therapy, chemotherapy and hemodialysis
Dental services (to the extent offered by the plan).

Non-covered services
Long Term Care Skilled Nursing Services
Medical Supplies
ICF/DD
Private Duty Nursing
Personal Care
Non-emergency transportation
Hospice
Comprehensive Medicaid Case Management
Home Health Services (except as noted above)
Over-the-counter Drugs
AIDS Adult Daycare
Home and Community Based Waiver Services
Alcohol and Substance Abuse Services ordered by local districts

Specific definitions for these services are included in the FHPlus model contract.